UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF OHIO
EASTERN DIVISION

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IN RE: NATIONAL PRESCRIPTION OPIATE LITIGATION

MDL No. 2804

Case No. 17-md-2804

Judge Dan Aaron Polster

This document relates to:
The County of Cuyahoga v. Purdue Pharma, L.P. et al., Case No. 18-OP-45090

City of Cleveland, Ohio v. Purdue Pharma L.P., et al., Case No. 18-OP-45132
The County of Summit, Ohio, et al. v. Purdue Pharma L.P., et al., Case No. 17-OP-45004

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Videotaped Deposition of
JOAN PAPP, M.D.
February 5, 2019
9:20 a.m.

Taken at:
Porter Wright Morris & Arthur LLP
950 Main Avenue, Suite 500
Cleveland, Ohio 44113

Stephen J. DeBacco, RPR

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ALSO PRESENT:

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EXHIBIT CUSTODY
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THE VIDEOGRAPHER: The date is February 5, 2019. We're on the record at a.m.

This is the deposition of Dr. Joan Papp in the matter of In Re: National Prescription Opiate Litigation in the United States District Court, Northern District of Ohio, Eastern Division.

Will counsel in the room please state appearances for the record.

MS. SCOLNICK: My name is Judy Scolnick, and I am a partner at Scott & Scott. We represent the Plaintiff, MetroHealth Hospital, which is not a bellwether plaintiff in the MDL.

MS. KOUBA: Annie Kouba with Motley Rice representing Plaintiffs.

MS. WILSON: Robin Wilson representing Plaintiff Cuyahoga County.

MR. MENDELSOHN: Clifford Mendelsohn from Tucker Ellis on behalf of Janssen Pharmaceuticals and Johnson & Johnson.

MR. HERMAN: Steven Herman from Zuckerman Spaeder on behalf of CVS Indiana, LLC, and CVS Rx Services Incorporated.

MR. MILLER: Hayden Miller from Ropes & Gray on behalf of Mallinckrodt, LLC, and SpecGx, LLC.

MR. DAVISON: William Davison of Ropes & Gray on behalf of Mallinckrodt, LLC, and SpecGx, LLC.

MS. McNAMARA: Colleen McNamara from Williams & Connolly on behalf of Cardinal Health.

THE VIDEOGRAPHER: Will counsel on the phone please state appearances for the record.

MR. HALPERN: Richard Halpern, Marcus & Shapira, on behalf of HBC.

MS. GATES: Lisa Gates from Jones Day on behalf of Walmart.

MR. LAZAR: Zachary Lazar of Morgan Lewis for the Teva Defendants.

MR. BADALA: Salvatore Badala, Cuyahoga County.

MS. HOSMER: Heather Hosmer of Arnold & Porter on behalf of Endo and Par Defendants.

MR. CIACCIO: Joseph Ciaccio, Napoli Shkolnik --

(Crosstalk.)

MS. SACKS: Hi. So that's Joe and -- Joseph Ciaccio and Shayna Sacks for Napoli Shkolnik, Cuyahoga County.

JOAN PAPP, M.D., of lawful age, called for examination as provided by the Federal Rules of Civil Procedure, being by me first duly sworn, as hereinafter certified, deposed and said as follows:

EXAMINATION OF JOAN PAPP, M.D.

BY MS. McNAMARA:

Q. Good morning, Dr. Papp.

A. Good morning.

Q. Could you please state your full name for the record?

A. Joan Papp.

Q. And what's your current address?

A. My home address is 27228 Worthington Lane, Olmsted Falls, Ohio 44138.

Q. Great. Have you ever been deposed before?

A. I have not.

Q. Great. So I'll just start out with a few simple ground rules to help it go smoothly today.

We have a court reporter who's going to be taking down everything we say, so it's important that we try our best not to talk over each other. So I will do my best to wait until you finish your answer before I start my next question, and I'd appreciate if you do the same for me. Fair?

A. Fair.

Q. And along the same lines, it can be difficult to transcribe an "uh-huh" or "uh-uh," so it's also important that you answer every question with a full word like a "yes," "no," or "okay." Fair enough?

A. Yes.

Q. And we will take periodic breaks throughout the day, but if at any time you need to take a break, just let me know and we'll do that. My only request is that if there's a question pending, you answer the question before we go off the record. Okay?

A. Okay.

Q. And is there any reason that you would not be able to provide truthful and accurate testimony today? Any medications, illness, anything?

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A. No.
Q. Great. So you understand that you are testifying today in connection with some ongoing litigation, correct?
A. Correct.
Q. And do you know who the plaintiffs are in the case in which you are testifying today?
A. I have reviewed the plaintiffs, yes.
Q. So you understand that Cuyahoga County and Summit County and City of Cleveland are the Plaintiffs?
A. Yes.
Q. Great. Do you know who the Defendants are?
A. The pharmaceutical companies, as well as distributors.
Q. And do you have an understanding of the allegations in the case?
A. Yes.
Q. And what's your understanding?
A. That misinformation was provided about the addictiveness of opioids, which led to overprescribing.

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Q. And you have an understanding of the relief that's being sought in this case?
A. Yes.
Q. And what's your understanding?
A. Damages and -- and financial damages.
Q. Do you know how much money is being claimed in damages?
A. I do not.
Q. And do you know whether MetroHealth has filed its own lawsuit against some of the Defendants?
A. Yes.
Q. And do you know the status of that lawsuit?
A. It is ongoing.
Q. And so you understand that you're here today to testify in your personal capacity about your own knowledge based on your experience as a doctor in Cuyahoga County, correct?
A. Yes.
Q. And you are not here to testify on behalf of MetroHealth --
A. Yes.

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Q. -- or to MetroHealth's view on anything?
A. Yes, I understand.
Q. So I will do my best to ask clear questions that make that clear. If at any point you're confused, just ask me to rephrase. Okay?
A. Okay.
Q. Great. So I want to start by talking a little bit about your professional background. So I'll hand you what I've marked as Exhibit 1.
MS. McNAMARA: There are a bunch of copies in the folder.
- - - - -
(Thereupon, Deposition Exhibit 1, Dr. Papp Bio, CUYAH_001688134, was marked for purposes of identification.)
- - - - -
MS. SCOLNICK: Does anyone else need them?
Q. Do you recognize Exhibit 1?
A. Yes.
Q. And what is it?

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A. This is a bio.
Q. Of you?
A. Of me, correct. Yes.
Q. And did you prepare this document?
A. Yes, I did.
Q. Okay. So it looks like, from your bio, that you graduated from the Medical College of Ohio in 2000; is that correct?
A. Yes, that's correct.
Q. And then you went to MetroHealth Medical Center in Cleveland for obstetrics and gynecology?
A. Yes, that's correct.
Q. And what was that? Was that a --
A. I did one year of residency in OB/GYN.
Q. And then you did a residency in emergency medicine, correct?
A. That's correct.
Q. What drew you to emergency medicine?
A. I enjoyed the rapid pace and caring for patients, and -- that had acute medical problems.
Q. And you completed your residency in

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2004; is that correct?
A. That's correct.
Q. And what did you do after you completed your residency?
A. I worked for Emergency Professional Services and was employed both at the Cleveland Clinic at Lakewood, and also at Lutheran. We worked through a contractor, EPS. I worked there until 2007.
Q. And in 2007 you joined MetroHealth?
A. I joined MetroHealth as a staff physician, that's correct.
Q. And just to back up for a second because we'll be mentioning MetroHealth today, MetroHealth is a hospital system, correct?
A. Yes.
Q. And so what's the structure of MetroHealth? Is there a central hospital and then satellite facilities?
MS. SCOLNICK: I'm going to object. Beyond the scope of the deposition.
But you can answer.
A. It's -- there's a main campus hospital, and there are satellite hospitals.
Q. And you work at the main campus?

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A. I primarily work at the main campus. I do occasionally do emergency department shifts at satellite emergency departments.
Q. Do you know approximately how many licensed prescribers are staff members at MetroHealth?
MS. SCOLNICK: The same objection and same instruction.
You can answer.
THE WITNESS: Okay.
A. There are about 950 staff medical providers.
Q. And what's the geographic scope of the patients you serve at MetroHealth?
MS. SCOLNICK: Objection. The same objection. It's beyond the scope.
Q. You can answer.
MS. SCOLNICK: And you can answer.
A. Cuyahoga County.
Q. Do you serve any residents of Summit County as well?
MS. SCOLNICK: Objection. The same objection.
You can answer.

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A. We -- we care for any patients who come through our doors.
Q. But mostly Cuyahoga County residents?
A. Primarily, just based on our location.
Q. And have you focused on emergency medicine the whole time since you joined MetroHealth in 2007?
A. Since 2007 I have been an emergency physician at MetroHealth.
Q. And have your duties and responsibilities changed over the years since you joined?
A. Yes, they have.
Q. Great. So let's start at the beginning and just kind of walk through chronologically.
A. Sure.
Q. So you joined as an emergen- -- as a staff physician in the emergency department?
A. That's correct.
Q. And what were your responsibilities in that capacity?
A. Clinical care of emergency

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department patients. There's also teaching responsibilities with medical students and residents, and a small percentage of my time was dedicated to administrative duties.
Q. And for how long did you hold that role as a staff physician in the emergency department?
A. Well, I -- it's an ongoing position, so I continue in that capacity. But my role changed, and I took on additional duties in 2012.
Q. And what were those additional duties?
A. I sought to develop a program to dispense naloxone to lay providers, Project DAWN.
Q. And -- and you started that in 2012 you said?
A. I began research in program development during that time. The program didn't begin until Sep- -- excuse me -- March of 2013.
Q. And when you took on responsibilities for Project DAWN, approximately how much of your time was devoted to that as opposed to

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practicing in the emergency room?
A. That's a difficult question to answer. My clinical time didn't formally change. I spent a number of hours outside of my regular clinical duties. At that time my clinical percentage was 90 percent. But I -- but I spent many hours outside of those formal hours doing work around the program development.
Q. Got it. So this was kind of an additional project on top of everything you were already -- you were already doing?
A. It was on top of my already-assigned duties.
Q. And have you taken on any other responsibilities since 2012?
A. Yes.
Q. And what are those?
A. In 2017 we opened an Office of Opioid Safety, with the mission to improve opioid safety throughout the community and MetroHealth through education, advocacy, and treatment.
Q. And that's an initiative within MetroHealth, correct?

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A. That is correct.
Q. And when you took that on, did that reduce your clinical time?
A. Yes, it did.
Q. By about how much percentage-wise?
A. It ranges between 40 and 50 percent, depending on how many programs I have going on.
Q. And when in 2017 did that launch?
A. July.
Q. July. And have you taken on any other responsibilities since then?
A. As -- as our program has developed, we have started many initiatives within the office.
Q. And what are those initiatives?
A. Boy, there's a lot. So I can start -- let's see. Where to start.
So we have a grant that allows us to form Quick Response Teams. It's a SAMHSA Grant. And that initiative involves a social worker and a police officer who form a team and respond to opioid overdoses in the community, typically within one week, meeting with the overdose victim and family, and an attempt is

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made to connect that victim and family to treatment. With the support of the family, of course.
Q. And I have some documents I'll show you later, so -- that might refresh your recollection on some other --
A. Okay.
Q. -- parts of it, so you don't have to remember.
A. Okay.
Q. Are there any others you can think of off the top of your head?
A. Yeah. So that's one program.
We have -- we've certainly expanded Project DAWN over the course of the six years that I've been functioning in this role. We have five walk-in sites. We have expanded Project DAWN to include opioid -- excuse me -- naloxone distribution in the emergency department, inpatient units, and in Cleveland EMS.
We also have developed a peer supporter program. We have collaborated with an outside agency called THRIVE that staffs our emergency department in other areas of our

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hospital with peer supporters. And those are individuals who are licensed by the State so that they can provide support and resources to patients who have either had an overdose in the emergency department or who are otherwise suffering from opioid use disorder. The goal is to connect them to treatment.
Another initiative that we've started is our education program throughout the hospital. We have hired two full-time opioid educators in our office to help develop curriculum to educate both providers and community on just general awareness of the opioid epidemic, as well as a curriculum dedicated toward safer prescribing for staff providers in our hospital.
We have a community educator that focuses more on education in the community, raising awareness of the opioid epidemic.
We also received a grant from Ohio Mental Health and Addiction Services that funds a full-time case manager in our emergency department who helps us to connect patients to treatment. And she is a nurse practitioner who also is licensed to prescribe buprenorphine for

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treatment of opioid use disorder.
We also supported an initiative to increase access to medication-assisted treatment by -- we hosted several waiver trainings at MetroHealth and level-of-care trainings for our providers at MetroHealth.
Let me think. What else?
We -- I know I'm probably forgetting some really obvious ones.
We have a program in the jail. We received a grant to connect inmates with treatment in the jail. This is still very early in the development phase and implementation phase, so it's not a fully developed program, but we're working to grow that program currently.
I'm sure there are others. I -- not jumping to the forefront of my mind right now, unfortunately.
Q. No problem. Understood. So not an exclusive list.
A. Not an exclusive list.
Q. Fair enough. And all of those things that you've described are things that you've done since July 2017?

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A. Except for the expansion of Project DAWN. That has been ongoing since 2013. That's been a steady growth over time.
Q. Got it. So aside from Project DAWN, these are all new initiatives?
A. That's correct.
Q. And so when you started Project DAWN, you started your initial research back in 2012. It seems like there was a bit of a gap between when you started researching and when the program actually got off the ground.
A. Sure.
Q. Did you encounter any resistance from anyone within MetroHealth or the community to the idea of -- actually, strike that. Let me back up and just say --
A. Sure.
Q. -- so can you explain a little bit about what Project DAWN is?
A. Sure. Project DAWN stands for "deaths avoided with naloxone." It's an opioid education and naloxone distribution program. This is a program that was initially started by the Ohio Department of Health as a pilot project in Southern Ohio. When I learned about

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the program, I wanted to adapt the program for Cuyahoga County and expand it, and we did just that.
And again, we have some walk-in sites, and we have expanded naloxone access to our inpatient units, our emergency department, and various other sites.
Q. So do you recall when that pilot project in Southern Ohio was first launched?
A. I believe it was 2012.
Q. And when did you learn about it?
A. In 2012.
Q. Okay. Got it.
And what made you want to adopt and expand it for Cuyahoga County?
A. I had read about those programs, and they were found to be effective in other areas.
Q. And naloxone is an antidote for an opiate overdose specifically, correct?
A. An opioid overdose, correct.
Q. And were you, at the time of 2012, as someone working in the emergency room, seeing an increase in the number of opioid overdoses that were --

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A. Yes.
Q. -- happening in the community?
A. Yes.
Q. And so that was what made you want to bring Project DAWN to Cuyahoga County, correct?
A. In part, yes.
Q. And so Project DAWN trains people to administer naloxone, one of the things it does; is that accurate?
MS. SCOLNICK: Object to the form.
You can answer.
THE WITNESS: Okay.
A. Project DAWN, in the community, provides opioid education to both people who are actively using opioids and people who may be in a position to rescue them. And we educate on risk factors for overdose. We recognize -- on how to recognize an opioid overdose and how to respond to an opioid overdose with rescue breathing, and calling 911, and administering naloxone. And naloxone kits are dispensed.
Q. And so now to circle back to my original question that I kind of jumped ahead

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to. When you were in the process of researching the possibility of bringing Project DAWN, did you encounter any resistance in the community to the type of education and response training that Project DAWN offers?
A. Very little.
Q. But some?
A. It was a new concept, and so we did get some public concern that perhaps this was not -- not the best idea. But otherwise, we got very little resistance from the medical community and very little resistance from the County.
Q. And the public concern that you did get, what did you do to respond to that?
MS. SCOLNICK: Object to the form.
A. We did a lot of public awareness events. We spoke at libraries and we spoke at -- in the community churches. All -- all of -- just a variety of forums to really get the message out that this was a safe and effective way to manage overdoses.
Q. And so to circle back for a minute to your role at -- or the creation of the Office of Opioid Safety at MetroHealth, what's

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your role with respect to the Office of Opioid Safety?
A. I'm the founder and medical director.
Q. And do you know whose decision it was to create the Office of Opioid Safety?
A. My -- my responsibilities increased between 2012 and 2017, and because of that I approached our chief clinical officer, Dr. Boulanger and requested additional time to work on this effort, and he suggested that we create an expanded office, including staff, to support the work that I was doing.
Q. And how many staff are currently in the Office of Opioid Safety?
A. I believe we have 15 as of now.
Q. So as somebody who has practiced medicine for -- for many years, you do prescribe medication, correct?
MS. SCOLNICK: I'm going to object to that question.
Do you want to go off the record?
MS. McNAMARA: Do we need to?
MS. SCOLNICK: I just don't want to clutter up the record if we don't need to.

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Mr. Masters wrote me an e-mail that I could find that said not only is she a fact witness and not representative of MetroHealth, but she is also not an expert. So that's part of the -- she's -- your question to me sounds like it was presuming an expertise. I think that was in -- the word in the question. So that's the reason for my objection. It's to the scope. She's not an expert. She's a fact witness.
MS. McNAMARA: Understood. I just asked if she prescribes medication, which I think is a fact question.
MS. SCOLNICK: I don't think that's what you asked, but she can certainly answer the question that you just asked now.
MS. McNAMARA: Fair enough. That was my intent, so I will clarify.
MS. SCOLNICK: Sure.
Q. Do you prescribe medication?
A. Yes, I do.
Q. And what are the factors that you personally consider when you are deciding whether to write a prescription?
A. I determine -- I take a history and

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a physical examination, and I determine the benefits of the medication versus the risk and make a decision, based on my medical knowledge, if a medication is indicated.
Q. And what information do you rely on to figure out the benefits of a medication?
A. That's a -- kind of a very broad question. Studies of effectiveness.
Q. Do you rely on the FDA-approved labeling?
A. Yes.
Q. And do you also rely on the FDA-approved labeling to determine the risks?
A. Yes.
Q. And do you rely on any other sources of information to determine the risks?
A. We look to the medical literature.
Q. Have you personally ever prescribed an opioid?
A. Yes.
Q. And has the frequency with which you prescribed opioids changed over time?
A. Yes.
Q. How so?
A. I have decreased the prescribing of

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opioids over time.
Q. Do you have a sense of how much you've decreased? The percentage?
A. I don't know that number.
Q. When you started at MetroHealth back in 2007, what was your understanding regarding the appropriate circumstances to prescribe an opioid?
A. During my training I was taught that patients should not have to experience pain, and that we should be very aggressive about treating their pain, and that opioids were a safe and effective treatment.
Q. And what training are you referring to specifically?
A. My emergency medicine residency training.
Q. And that was at MetroHealth?
A. That's correct.
Q. And when you prescribed opioids back in -- in 2007, you prescribed them based on your clinical judgment of the patient's legitimate medical need, correct?
A. I did an assessment of the risks and the benefits, and if the benefits

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outweighed the risks, I chose to prescribe, in my assessment at the time, based on the information that I had.
Q. Has your understanding of the appropriate circumstances in which to prescribe an opioid changed over time?
A. Yes.
Q. How so?
A. I was not aware of the extent of the risks associated with opioids, and so that balance of risk versus benefit has changed for me.
Q. And what information -- strike that.
What sources of information have come out since 2007 that helped change your understanding?
A. One of the most influential publications that I look back to is the CDC MMWR report in 2012 that first described the prescription drug opioid epidemic. I, prior to that time, was not fully aware of the risks and the number of opioid overdose deaths and addiction that was occurring.
Q. So you were aware, prior to 2012,

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that opioids were addictive, correct?
A. I was.
Q. But you're -- you weren't aware of the extent to which they were addictive? Am I understanding correctly?
A. I think so. And I -- I think I'm -- I was also not aware of the extent to which they were causing fatal overdoses.
Q. And when you say "the extent to which they were causing fatal overdoses," are you referring to overdoses where the prescription opioid was the sole cause of the overdose?
A. I'm referring to opioid overdoses in totality.
Q. So that would include overdoses in which there were multiple drugs present, including an opioid?
A. Correct.
Q. And to back up again, so we are on the same page in -- terminology-wise. Opioids and opiates, is there a distinction between the two in your mind?
A. Yes.
Q. What's that distinction?

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A. "Opioid" is a term that encompasses all medications that are either synthetic or semisynthetic, or also encompasses opiates, which are the naturally occurring substances of the poppy plant.
Q. So "opioids" is the broader term?
A. "Opioids" is the broader term.
Q. Got it.
When you started at MetroHealth back in 2007, did you follow any written guidelines for the prescribing of opioids?
A. I wasn't aware of any either state or national guidelines on safe opioid prescribing at that time.
Q. And have you become aware of any such written guidelines since then?
A. Yes.
Q. And I know there are a bunch, so I'll table that and show them to you later.
A. Sure.
Q. Have you ever written a prescription for opioids for a patient that you did not think was medically appropriate based on what you knew at the time?
MS. SCOLNICK: I'm going to object

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to the question, to the form.
A. Can you restate the question?
Q. Sure. Has there ever been an instance in which you wrote an opioid prescription that you did not think was based on legitimate medical need?
A. No.
Q. And you've treated patients in the emergency room for the effects of an opioid overdose, correct?
A. Yes.
Q. Is there any difference in how you treat a patient who overdosed on one type of opioid versus another? Say, heroin versus oxycodone?
A. It depends.
Q. What does it depend on?
A. The half-life of the medication.
Q. So are there some opioids that have a longer half-life than others?
A. Yes.
Q. And what are the ones that are on the longer half-life side of the scale?
A. Methadone, OxyContin.
Q. And what are some of the ones with

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the shorter half-life?
A. Oxycodone. Immediate release; I should clarify.
Q. And what's the relevance of the half-life when it comes to treating an overdose? Strike that.
What's the relevance of the half-life when it comes to how you treat an overdose?
A. I would observe the patient for longer if the medication has a longer half-life. Oftentimes we would admit a patient if they have overdosed on a medication with a longer half-life.
Q. When you treat a patient for an overdose, do you or anyone on your team attempt to figure out whether the person has overdosed on a prescription opioid versus an illicit opioid?
A. We ask the patient what medication or drug they ingested.
Q. And do you record the answer anywhere?
A. In the docu- -- medical documentation in the electronic health record.

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Q. And have you ever run any reports on that medical documentation that quantify the number of overdoses from prescription opioids versus illicit opioids?
A. No.
Q. To your knowledge, is that possible?
A. No.
Q. Have you treated patients for any other side effects of opioids?
A. Yes.
Q. What are those?
A. Constipation. We often see patients with illicit drug use who have skin and soft tissue infections, other infectious diseases related to injection of opioids. We see oversedation. We see patients presenting with withdrawal as well. And oftentimes patients present with opioid use disorder seeking treatment.
Q. And that's all in the context of the emergency room?
A. That's correct.
Q. Are you required to take any CMEs, continuing medical education courses, in order

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to retain your medical license?
A. No.
Q. Have you opted to take any CMEs since you got your medical license?
A. Yes.
Q. Have you taken any related to pain management over the years?
A. Yes.
Q. And when was that?
A. I don't recall the exact date.
Q. Was it within the last five years?
A. Yes.
Q. Within the last two years?
A. Yes.
Q. Any pain management CMEs before that?
A. I don't recall.
Q. Do you recall who, if anyone, sponsored the pain management CME that you took?
A. I don't recall.
Q. Have you taken any CMEs on opioid prescribing?
A. Yes.
Q. And when was that?

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A. Within the same time frame. I don't recall exact dates.
Q. And just to circle back for a second to the pain management, was that an in-person class?
A. I have attended both inpatient [sic] and online courses.
Q. And was the in-person class at MetroHealth?
A. No.
Q. Where was it?
A. I took a class at -- it was in Columbus as part of the American College of Emergency Physicians.
Q. And the opioid prescribing CMEs -- CME, was that in person?
A. I had both in-person and online training.
Q. And where was the in-person training held?
A. We held a SCOPE of Pain course at -- at MetroHealth, although it was actually off campus, but we -- we hosted a SCOPE of Pain training. That was a live training. And I also did the same SCOPE of Pain training online

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as well.
Q. And do you recall who presented or who taught the SCOPE of Pain course?
A. I don't remember his name off the top of my head. If you know it --
Q. I don't. I don't. But if it pops into your head.
Have you ever taken a CME on preventing diversion of controlled substances?
A. I'm sorry. Could you repeat one more time?
Q. Sure. Have you ever taken a CME on preventing diversion of controlled substances?
A. Not that I recall.
Q. Have you taught any CMEs?
A. Yes.
Q. And what were the subject of those?
A. Let me think. Naloxone, distribution and benefits of lay-access naloxone. I've given lectures and grand rounds to the residents and medical students on the opioid epidemic. I've also given grand rounds and other lectures to medical students on other topics outside of the opioid crisis.
Q. And what are grand rounds?

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A. It's a CME lecture for medical staff, residents, and medical students.
Q. And you mentioned early on, when we started talking about your background, that you had some teaching responsibilities for medical students?
A. Correct.
Q. And you've done that since you started at MetroHealth in 2007?
A. Yes.
Q. And in addition to grand rounds courses, what else do you teach?
A. We do bedside teaching with medical students and residents. We do brief lectures during shifts. We have more formal education on Wednesday mornings, one-hour lectures. I've often been requested to speak to other departments in my hospital on a variety of topics, including opioid-related issues.
Q. Are you aware that Cuyahoga County has an opiate task force?
A. Yes.
Q. For how long have you known about the opiate task force in Cuyahoga County?
A. Since 2012.

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Q. How did you learn about it?
A. I met the supervisor and director of that task force, Vince Caraffi.
Q. Are you a member -- are you currently a member of the opiate task force?
A. Yes.
Q. Are you on any committees within the opiate task force?
A. No.
Q. And have you been a member since 2012?
A. Yes.
Q. And is Project DAWN affiliated with the opiate task force in any way?
A. We -- let me think if we've had any.
Well, we do have Project DAWN -- one of our -- one of our sites is at the county board of health at the Parma location, and I've collaborated with Vince Caraffi at various times throughout the years to support our program.
Q. On Project DAWN, what makes up -- strike that.
How is Project DAWN funded?

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A. We have a variety of funding streams, and it's changed over the course of the past six years.

We have funding through MetroHealth. We originally received some money from Ohio Department of Health. We've received money from Cuyahoga County. Currently, we have, additionally, a variety of funding sources: Money from the ADAMHS Board, money through the SAMHSA Grant, and I believe we still have some funding from Ohio Department of Health as well.

Q. Do you know an approximate percentage of -- or what percentage of funding for Project DAWN comes from Cuyahoga County?

A. I don't recall.

Q. Is it less than 25 percent?

A. I couldn't state that with confidence.

Q. And what does the funding for Project DAWN cover?

A. It covers naloxone. To some degree it covers staffing. It covers kits, which include a bag, some printed materials, airway barrier masks for rescue breathing, and other

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promotional materials.

Q. So does Project DAWN purchase the naloxone?

A. We purchase most of the naloxone, yes. Some is supplied to us from other sources, like the Ohio Department of Health.

Q. So some is -- is given; the rest you purchase?

A. Correct.

Q. And from where do you purchase it?

A. Through our pharmacy department at MetroHealth.

Q. Aside from -- well, aside from Project DAWN, are you involved with any other specific opiate task force initiatives?

A. Yes.

Q. What are those?

A. U.S. attorney's heroin task force. I am a member, and I chair the policy subcommittee.

I am also a member of the hospital consortium. I'm not sure. The exact title is --

Q. Northeast Ohio --

A. Northeast Ohio --

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Q. Yep. Got it.

A. -- Opioid Hospital Consortium, I think. Yeah, that's right. And I serve on the executive leadership committee.

I am also the chair of the Ohio Hospital Association Opioid Response Initiative.

Within MetroHealth, I serve on two committees. I chair two committees. One is our opioid safety task force, and the second is our controlled substance peer-review committee. I think that's it.

Q. Okay. I wanted to make sure you were done.

So to circle back to the U.S. attorney's opiate task force, when did that start?

A. 2015.

Q. And when did you join?

A. At its inception.

Q. And how did that come about?

A. The U.S. Attorney, at the time, convened a group of local stakeholders with the purpose of delivering a conference on heroin awareness.

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Q. And that conference happened in 2013?

A. That's correct.

Q. And did the task force continue on after the conference?

A. Yes, it did.

Q. And have there been any other areas of focus for the task force since 2013?

A. Sure. After the conference we developed a community action plan developed around some prior- --- priority areas: education, treatment, law enforcement, and policy.

Q. And you were specifically involved in the policy section?

A. Yes, that's correct.

Q. And were there -- what were the -- strike that.

Were there any specific policies that -- that your subcommittee focused on over the years?

A. Yes. Initially, we focused on expansion of naloxone. We lobbied to support state law that would expand access to naloxone.

Q. Any others?

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A. We supported the Good Samaritan legislation. We also worked with the medical board to provide feedback on medical board rules around office-based opioid treatments. And we also collaborated with other lawmakers on a variety of local and federal policy.
Q. Were there any -- have there been any policies that your subcommittee has opposed over the years?
A. I don't recall.
Q. And was it the U.S. attorney in Cleveland who convened the task force?
A. Yes, that's correct.
Q. And do you have a sense of the geographic area that's encompassed by the activities of the task force?
A. It includes the Northern District of Ohio, which is the jurisdiction of the U.S. attorney. That's much broader than the practical group that met. We tended to be folks from Northeast Ohio.
Q. But it was intended to cover an area broader than just, say, Cuyahoga County and Cleveland; is that fair?
A. I -- I think others from Western

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Ohio were also invited to attend and participated as needed.
Q. You also mentioned the Northeast Ohio Opioid Hospital Consortium?
A. Yes, that's correct.
Q. What is that?
A. It is a consortium of local hospital leaders who have convened to address the opioid crisis, as best served by hospital systems.
Q. When was that formed?
A. I believe that was 2016 or 2017? I don't recall the exact date.
Q. Within the last couple years?
A. Yes.
Q. And have you been involved since the start of that?
A. Yes.
Q. And are there any specific initiatives or aspects of the opioid crisis that the consortium has focused on?
A. Yes.
Q. What are those?
A. Education for nurses and naloxone access in hospitals.

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Q. And why education for nurses?
A. That's an area that largely has not been focused on in the past, and we felt that that was a gap that needed to be filled.
Q. Are nurses able to prescribe opioids?
A. No.
Q. So the -- was the education related to treatment of --
A. It was related to recognizing signs of opioid misuse, abuse, and other side effects.
Q. You also mentioned --
MS. McNAMARA: Oh, do you want to take --
MS. SCOLNICK: Just say on the record we've been at it for about an hour, and I was asking the witness if she wants a break.
MS. McNAMARA: Okay.
MS. SCOLNICK: Do you?
Because -- do you want to finish an area? I don't want to interrupt if no one's tired, but --
MS. McNAMARA: I was just going to ask about the Ohio Hospital Association, and

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then I'm -- then would actually be a really good time.
THE WITNESS: Okay.
MS. SCOLNICK: Okay.
Q. So you also mentioned that you were the chair of the Ohio Hospital Association Opioid Response Initiative?
A. Yes, that's correct.
Q. And what is that?
A. It is an organization -- well, the Ohio Hospital Association is a statewide organization that serves member hospitals. The opioid response initiative was formed by Paul Hicks, a physician, a leader at the Ohio Hospital Association.
And the goal of our opioid response initiative is to identify promising or known-to-be-effective interventions in hospital systems, and to evaluate outcomes, and disseminate best practice among hospital systems.
Q. And when was that initiative launched?
A. I believe it was 2017.
MS. McNAMARA: Good. Let's take a

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break.
THE WITNESS: Okay.
MS. McNAMARA: Thank you.
THE VIDEOGRAPHER: Off the record at 10:16 a.m.
(A recess was taken.)
THE VIDEOGRAPHER: Back on the record at 10:35 a.m.
Q. Welcome back.
A. Thank you.
Q. Just to circle back for a moment to the Northeast Ohio Opioid Hospital Consortium. Was prescriber training part of the mission of that group?
A. It has been part of the mission, yes.
Q. And has the group undertaken any initiatives related to prescriber training?
A. Not that I'm aware of currently.
Q. Are there any plans to do so? Any current plans to do so in the future?
A. Yes.
Q. And what are the plans for that?
A. I am not -- not aware of the immediate plans.

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Q. During the course of your practice and your work at MetroHealth, have you become familiar at all with the closed system of distribution for controlled substances?
A. No.
Q. Are you familiar with the term "diversion" in the context of controlled substances?
A. Yes.
Q. And what does that mean to you in the context of your practice and work?
A. Medications being diverted from normal, prescribed legal avenues to illegal or misuse of the medications.
Q. And as a doctor, do you understand prescribers to have any role in preventing the diversion of controlled substances?
A. Insofar as we educate patients on keeping medications safely stored to prevent diversion, yes.
Q. And what's the importance of safe storage of controlled substances?
A. Well, we know that these medications are frequently misused and diverted by family members, and I have taught our

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providers that it's important to educate patients to keep medications locked up and safely stored so that they are not diverted.
Q. And as the -- as the doctor who's prescribing the medication, is there any way for you to know in advance of writing the prescription that it might be diverted by a family member?
A. It's unlikely for me to have that information. Sometimes patients do volunteer that they have family members that have misused opioids in the past, but that's not the rule.
Q. Have you, during the course of your practice and work, developed an understanding of a pharmacist's role in preventing the diversion of controlled substances?
A. Yes.
Q. What's your understanding of that?
A. They report prescriptions to the PMP, the state PMP. They often will notify a physician directly if a prescription seems suspicious or altered.
Q. Have you ever been contacted by a pharmacist about a prescription for controlled substances that you wrote?

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A. I don't recall.
Q. But you don't understand pharmacists to be responsible for assessing the legitimate medical need of one of your patients, correct?
MS. SCOLNICK: Object -- object to the form.
A. I -- I understand the benefit of the clinical pharmacist and the practicing pharmacist's role in providing the medication to the patient. They often have information that is not available to me.
Q. And what information might a pharmacist have that you don't see as a physician?
A. They may see a patient's behavior at the pharmacy that seems suspicious. They may see a patient who has altered a prescription.
Q. Are you -- have you become familiar with the role of wholesale pharmaceutical distributors in the controlled substance supply chain?
A. No.
Q. Have you become familiar with the

role of manufacturers in the controlled substance supply chain?
A. Yes. I...
Q. And what's your understanding of the manufacturers' role?
A. That they perform the research and development of medications, they promote the medications, and they manufacture the medications.
Q. Are you aware that the DEA sets production quotas for certain controlled substances?
A. Yes.
Q. Including opioids?
A. Yes.
Q. Do you know what factors the DEA considers in setting the quotas?
A. I do not.
Q. But you are aware that production of opioids is limited to the quotas set by DEA, correct?
A. Only very -- in very broad terms.
Q. And it's your understanding that a person can't lawfully obtain a prescription opioid without a legitimate prescription

written by a licensed prescriber, correct?
A. Yes.
Q. And in addition to FDA-approved prescription opioids, there -- you're also aware of a number of illicit opioids, correct?
A. Yes.
Q. Including heroin?
A. Yes.
Q. Analogues of fentanyl?
A. Yes.
Q. Carfentanil?
A. Yes.
Q. And you're aware that manufacturers -- drug manufactures don't manufacture those illicit opioids, right?
A. Yes.
Q. And wholesale distributors don't distribute those, correct?
A. Yes.
Q. And they're not prescribed by doctors like you, right?
A. That's correct.
Q. Before the break we talked a little bit about opioids being addictive. Do you recall that?

A. Yes.
Q. And when -- when we say that a drug is addictive, what does that mean?
A. Well, addiction starts as a physical dependence. The body becomes dependent on the medication. But the addiction progresses when there are maladaptive behaviors that accompany that physical and psychological dependence on the opioid medication.
Q. And what do you mean by "maladaptive behaviors"?
A. An excessive desire and craving to obtain the drug, engaging in sometimes criminal or other, I guess, unethical behavior to obtain the drug. They're typically disregarding family and friends and engaging in behavior that is -- is not their norm.
Q. And in your experience, does everyone who takes a prescription opioid eventually become addicted to the drug?
A. No.
Q. And do you understand some prescription opioids to be more addictive than others?
A. Yes.

Q. Which are the more addictive, to your knowledge?
A. The higher DEA classes, so C2 and C1.
Q. Do you have a sense of how many patients who are prescribed opioids by a doctor eventually end up addicted to them?
A. I don't think that that's a known factor.
Q. In your experience, have some people -- strike that.
So in your experience, have you come to see that some people are more likely to become addicted to opioids than other people?
MS. SCOLNICK: Object to the form.
But you can answer.
A. Yes.
Q. And what are the factors that make somebody more likely to become addicted?
A. Factors may include age, gender, past history of substance use, family history of substance abuse, and psychological disease.
Q. And as part of your decision about whether to prescribe an opioid, do you consider those factors in deciding whether the drug is

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appropriate?
A. I use those fact- -- factors to determine risk versus benefit.
Q. So -- so it's always a balance, risk versus benefit, anytime you're deciding whether to write a prescription for opioids, correct?
A. Correct.
Q. So there might be a situation where -- so in your experience, has there been a situation where the factors indicate that the person might be likely to become addicted, but the benefit ultimately outweighs that risk?
A. Yes.
Q. And each decision you make about whether to write an opioid prescription, then, is based on your determination of the risk/benefits to the individual, specific patient in front of you, right?
A. Yes.
MS. SCOLNICK: Objection. That's been asked and answered.
Q. And that patient-specific information that you consider, are you aware of that information being available to wholesale

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pharmaceutical distributors?
A. No.
Q. What about drug manufacturers?
A. No.
Q. And because you have access to all of that patient-specific information, do you believe that you, as a treating physician, are best able to make that risk-benefit decision about whether to prescribe an opioid?
MS. SCOLNICK: Object to the form. But you can answer.
A. We make decisions based on the information that is available to us. And each individual decision is based on the current available literature, as well as evaluating those factors that we know to be risks for opioid misuse and harm.
Q. But you believe that you, as a physician, are better positioned to make that risk-benefit analysis than, say, a third-party payer like an insurance company?
MS. SCOLNICK: Object to the form.
A. I -- I'm in a more proximate position, yes. I understand what's going on directly with the patient.

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Q. And you're better positioned than a wholesale pharmaceutical distributor?
MS. SCOLNICK: Object as to form.
A. Yes.
Q. And a drug manufacturer?
MS. SCOLNICK: Object as to form.
A. Yes.
Q. So as a practicing physician, do you keep up to date on relevant prescribing guidelines for prescription opioids?
A. Yes, I do.
Q. And sitting here today, which -- what guidelines are you aware of relating to opioid prescribing that you have considered in your practice?
A. I am aware of the 2016 CDC guidelines for safer opioid prescribing. I am aware of our state's guidelines for opioid prescribing. We also have state law, as well, that has recently been enacted, both for the setting of acute and chronic pain.
Q. Since you joined MetroHealth in 2007, has MetroHealth done anything to ensure that you, as a physician, keep up to date on the relevant prescribing guidelines for

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opioids?
MS. SCOLNICK: Object. Beyond the scope.
THE WITNESS: Do I answer?
MS. SCOLNICK: Yes.
A. Yes. Our Office of Opioid Safety has held town hall meetings for all of our providers. They're mandatory. We've also made available other online tools.
Q. And the -- the mandatory town halls, did they start after the Office of Opioid Safety was launched?
A. Yes, that's correct.
Q. So that would be after July 2017?
A. Yes, that's correct.
Q. And before that, do you recall MetroHealth doing anything to make sure that you were aware of the relevant prescribing guidelines for opioids?
MS. SCOLNICK: Beyond the scope. Objection.
You can answer.
THE WITNESS: Okay.
A. We notified prescribers by e-mail of updates from the medical board. We held a

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full-day conference on prescribing guidelines. We held a full-day conference on the stigma of opioid abuse, in which there was a panel on policy.

I updated the medical staff when policy changes were made. We made an online module mandatory for providing an update on all state and -- I think it was only state law.

Q. And do any of those efforts go -- date all the way back to 2007 when you started?

A. No.

Q. When did they start?

A. Of those --

Q. Let me strike that --

A. Yeah.

Q. -- because that's a really broad question.

What's the earliest one you can remember?

A. I believe it was 2014 when we updated our policy for the first time.

Q. And is it fair to say that the state guidelines for opioid prescribing have changed considerably over the past 10 years?

A. Prior to 2014, I'm -- I wasn't

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aware. There may have been guidelines, but I was not aware of them. But guidelines were released around that time from the state medical board, both for acute and chronic pain management.

Q. And -- and MetroHealth also issued guidelines for chronic opioid management, correct?

A. We have a policy.

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(Thereupon, Deposition Exhibit 2, Document Titled "MHMC Guidelines for Chronic Opioid Management," MH000000027 to 000000036, was marked for purposes of identification.)

- - - - -

Q. I'm going to hand you what I've marked as Exhibit 2.

Exhibit 2 is a document Bates-labeled MH000000027. The title on the top is "MHMC Guidelines for Chronic Opioid Management."

A. Yes.

Q. Have you seen this document before?

A. It looks familiar. I have not

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reviewed it in detail.

Q. Haven't reviewed it in detail ever, or just not recently?

A. Not recently.

Q. The bottom left-hand corner, there's a date, June 22, 2011. Do you see that?

A. Yes, I do.

Q. And do you recall reviewing these documents around that time?

A. No. I -- I was not -- I did not participate in creating this document or reviewing it.

Q. Approximately when was the first time you recall reviewing it?

A. I do not recall.

Q. Do you know who was responsible for drafting these?

A. The chairman of emergency medicine.

Q. And is that Charles L. Emerman, M.D., whose --

A. Yes.

Q. -- name is in the lower right corner?

A. Yes, that's correct.

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Q. And he was the chief of emergency medicine, you said?

A. The chairman --

Q. Chairman.

A. -- of the department.

Q. In the lower left-hand corner, underneath the date, it says "Opioid Management Task Force." Do you see that?

A. Yes, I do.

Q. What is the Opioid Management Task Force?

A. I'm not familiar with that task force.

Q. And you said that MetroHealth had a policy for prescribing controlled substances?

A. Correct.

Q. Is this one of the policies you were referring to?

A. No.

Q. Is this something different, in your mind, from a policy?

MS. SCOLNICK: Object to the form. But you can answer.

A. Yes. A guideline sets best -- best practice, typically based in evidence-based --

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evidence, and a policy is a rule.
Q. So realizing this is a gross simplification, but do you understand a guideline to be helpful but not mandatory, and a policy mandatory?
A. Yes.
Q. Okay. Do you know whether the Opioid Management Task Force still exists?
A. It does not.
Q. Do you know when it --
A. Right. Let me -- let me clarify. I'm not familiar with this -- this task force. I believe that -- I -- I can't speak to that -- that task force.
Q. Got it.
So about halfway down the first page of the document, the third full paragraph, it says, "The decision to initiate or continue chronic opioid management, like all decisions in medicine, must balance risk versus benefit."
Do you see that?
A. Yes.
Q. And is that the type of risk-benefit analysis that we've been discussing today?

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A. Yes.
Q. Now, this particular document, Exhibit 2, has this document influenced your decisions about whether to prescribe opioids in terms of how to perform that risk-benefit analysis?
MS. SCOLNICK: Objection.
You can answer that.
MS. McNAMARA: Yeah. Let me strike that. That's a terrible question. Don't start if you don't know where you're going to stop.
Q. Has this -- in your practice did this particular document, Exhibit 2, influence at all your opioid prescribing?
A. No.
Q. Okay. On the fourth page of the document, the -- it has a number in the lower right-hand corner that ends with 30. It's a narcotic management agreement. Do you see that?
A. Yes.
Q. And are you familiar with narcotic management agreements?
A. Yes.
Q. What are they?

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A. They are agreements between the patient and the provider that a provider will perform a duty to prescribe the medication, and the pa- -- it outlines, essentially, both the physician's responsibilities and the patient's responsibilities.
Q. And have you ever entered a narcotic management agreement with one of your patients?
A. No.
Q. Do you, as a result of your work at MetroHealth, have an understanding of when a narcotic management agreement is appropriate?
A. Yes.
Q. What's that understanding?
A. Ongoing chronic opioid therapy.
Q. And I take it because you work in the emergency room, you do not handle ongoing chronic opioid therapy?
A. That's correct.
Q. And so you said that the -- that Exhibit 2 did not influence your prescribing decisions. Why not?
A. I don't prescribe medications for chronic opioid therap- -- I don't,

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essentially, prescribe in this setting. I don't prescribe opioids for chronic pain management.
Q. And this document relates to prescribing for chronic pain management?
A. That's -- I think that's the title of it, "Guidelines for Chronic Opioid Management."
- - - - -
(Thereupon, Deposition Exhibit 3, 2/1/2013 E-Mail from Vince Caraffi Re: Updates/Information From, with Attachment, CLEVE_000220806 to 000220816, was marked for purposes of identification.)
- - - - -
Q. I'm going to hand you Exhibit 3. Exhibit 3 is a document that starts with Bates label CLEVE_000220806. And the cover document is an e-mail from Vince Caraffi to a number of different recipients, dated February 1, 2013.
A. Uh-huh.
Q. So you are one of the recipients --
A. Yeah, I'm a recipient. I see that.

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Q. -- of the -- of the cover e-mail.
But I am interested in the --
A. The other --
Q. -- the attachments, the first of which is the "Ohio Emergency and Acute Care Facility Opioids and Other Controlled Substances (OOCS) Prescribing Guidelines."
Do you see that?
A. Yes.
Q. It rolls off the tongue.
A. It does.
Q. So in the lower left-hand corner, it says, "Approved by GCOAT on April 18, 2012."
Do you see that?
A. Yes.
Q. And do you know what GCOAT is?
A. Yes.
Q. What is that?
A. The Governor's Cabinet Opioid Action Team.
Q. And so these are guidelines that relate to your specific area of practice, correct?
A. Yes, that's correct.
Q. So when did you -- and -- and have

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you seen this document before?
A. Yes.
Q. When was the first time you recall seeing these guidelines?
A. Probably about the time that it was released.
Q. And how did you become aware of these guidelines at the time?
A. I don't recall, but probably through the opiate task force.
Q. And Mr. Caraffi, who sent the e-mail, is the chairman of the opiate task force?
A. Yes.
Q. Were you aware of any guidelines issued by the State before 2012 that related specifically to emergency and acute care facility opioid prescribing?
A. Not to my knowledge.
Q. Do you have an understanding as to why these guidelines were issued in 2012?
A. I think there was a growing concern of misuse and abuse of opioids prescribed in the emergency department.
Q. And did you personally, at the

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time, observe misuse and abuse of opioids that were prescribed in the emergency department at MetroHealth?
MS. SCOLNICK: Object to the form.
A. I see patients one time, typically. And I could not speculate on the use of the medications that I prescribed after the patient left the emergency department.
Q. So do you have an understanding as to why there was a growing concern about misuse and abuse of opioids prescribed by emergency departments?
A. Yes.
Q. What's that?
A. We saw an increased number of fatalities from opioid overdose nationwide. And I -- I think there was a concern that we needed to look at all sources of opioid medications. Opioid medications are commonly prescribed from the emergency department because the majority of patients who are seen in the emergency department and treated have a painful condition.
Q. And when you say they have a painful condition, you're referring to a -- an

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acute painful condition generally? Or could it be chronic as well?
MS. SCOLNICK: Object to the form.
A. Patients can present with both acute and chronic pain in the emergency department.
Q. When you first read these guidelines, did they influence in any way the risk-benefit analysis that you undertake when you're deciding whether or not to prescribe an opioid?
A. Yes. I think this emphasized that growing concern of the harms of opioid medications.
Q. You testified earlier that initially you weren't aware of the extent to which opioids were addictive.
A. Right.
Q. Is that fair?
A. That's fair.
Q. And is -- is this particular document, these guidelines, something that helped change your understanding?
A. I think it did. I think there was a -- a growing interest in learning more about

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the addictiveness of opioid medications about the time that these guidelines were released.

We also saw that MMWR report from the CDC that declared an opioid prescription -- prescription painkiller epidemic. And so I think many physicians decided to start doing a little bit more independent research and evaluating the harms and -- and sort of doing a reassessment of the harms versus the benefits.

Q. So this is something that prompted further inquiry?

A. Correct.

Q. Did these guidelines actually change your prescribing practices with respect to opioids at all?

A. Yes.

Q. How so?

A. Can I spend a moment to review?

Q. Take your time.

A. Okay.

(Telephonic interruption.)

MS. McNAMARA: Can the people on the line mute their phones, please?

A. I would -- I would say that No. 7 was a change in my practice. We often

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prescribed for longer than a three-day supply. After this recommendation was created, I made a concerted effort to reduce that to a three-day supply.

Q. And No. 7 says, just for the record, "Except in rare circumstances, prescriptions for OOCS should be limited to a three-day supply. Most conditions seen in the emergency/acute care facility should resolve or improve within a few days. Continued pain needs referral to the primary care physician or appropriate specialist for reevaluation."

Did I read that correctly?

A. Yes.

Q. And that's what you were referring to?

A. Yes.

We also reevaluated our discharge instructions and information that we provided to patients after these guidelines were prepared.

At one point we had a guideline similar to this posted on the wall in our emergency department to inform patients of our guidelines, which pertains to No. 8 and No. 9.

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Q. With respect to No. 7, the guideline for limiting prescriptions to a three-day supply, you said that before this guideline you would typically prescribe for longer?

A. I wouldn't say that I typically prescribe. I would say that there were cases in which I did prescribe longer than three days.

Q. And what was the benefit, in those cases, of prescribing for longer?

MS. SCOLNICK: Object to the form.

A. My assessment of risk versus benefit was related to a misunderstanding of the potential harms with the medications when taken for a longer duration of time.

Q. And when you say misunderstanding of the harms for a longer duration of time, what are you referring -- what harms are you referring to relating to the longer duration?

A. Increased risk associated -- the increased risk of addiction and dependency associated with a longer duration of being on the medication.

Q. And do you understand that risk of

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addiction and dependency to increase even if the person takes the drug as you've prescribed it?

A. Yes.

Q. Did anything in this document itself change your understanding -- change your underlying understanding of the addictiveness of opioids?

A. No. But as I stated before, it prompted further inquiry.

Q. And it -- did it prompt further inquiry by you yourself?

A. Yes.

Q. What did you do?

A. I researched addiction and sought to learn more about the addictive nature of medications.

Q. So how did you -- how did you go about doing that? Did you review the medical literature?

A. Yes.

Q. And is there anything -- I know you mentioned the 2012 CDC -- MWR?

A. Yes.

Q. Okay.

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A. Morbidity and mortality report.
Q. Was there anything -- anything else that you recall as helping to change your understanding of the addictiveness of opioids?
A. I participated in the SCOPE of Pain prescribing course.
Q. And when was that?
A. I don't recall.
Q. Was that around the 2012 time period or more recently?
A. It's -- I don't recall.
Q. And when you -- when you were researching addiction -- so I had asked about reviewing medical literature, and you mentioned the SCOPE of Pain course.
Was there anything else that you did to learn more about the addictiveness of opioids?
A. I reviewed medical literature. As to specifics, I can't -- I can't recall specific pieces of literature that I reviewed.
Q. And then from that review you started to understand that opioids were more addictive than you initially understood?
A. Correct.

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Q. But prior to -- prior to that research and prior to developing more understanding about addictiveness, you believed that the prescriptions you were writing were based on your risk-benefit analysis of what was appropriate for the patient; is that right?
A. That's correct.
Q. Based on the information you had at the time?
A. Based on the information that I had at the time, the prescriptions that I wrote, I believed that the benefit outweighed the risk.
Q. To your knowledge, did your colleagues -- strike that, to back up for a second.
So during the course of your work in the emergency room, have you been able to develop any sort of understanding of your colleagues' prescribing practices with respect to opioids?
A. Yes.
Q. And to your knowledge, have your colleagues also followed point No. 7 in the guidelines about limiting prescriptions to a three-day supply?

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A. Yes.
Q. And that's been since 2012?
A. Yes.
Q. And do you understand your colleagues, like you, to always have been writing prescriptions based on their individual analysis of the risks and benefits of the medication?
MS. SCOLNICK: Object to the form. But you can answer.
A. I can't speak to my colleagues' decision-making in individual cases, but I -- I know and trust my colleagues, and their practice is typically an analysis of risk versus benefits just as -- as mine is.
Q. And you have no reason to believe that your colleagues are writing illegitimate prescriptions for opioids, correct?
MS. SCOLNICK: Object. Object as to form, and repetitive.
A. None -- none that I am aware of.
- - - - -
(Thereupon, Deposition Exhibit 4, Document Titled "The MetroHealth System Policies Controlled Substance

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Prescribing Policy," MH000000272 to 000000279, was marked for purposes of identification.)
- - - - -
Q. So I'm going to hand you Exhibit 4. Exhibit 4 is Bates-labeled MH000000272.
So have you seen this document before?
A. Yes, I have.
Q. What is this document?
A. This is our controlled medication safety committee, and pharmacy and therapeutic safety committee controlled substance prescribing policy.
Q. So when you referred earlier to a MetroHealth policy, is this the document you were --
A. This is the document.
Q. And to kind of circle back to our discussion of guidelines versus policies, this document says it's a policy, correct?
A. Yes.
Q. So you understood this document -- compliance with this document to be mandatory?
A. That's correct.

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Q. As opposed to Exhibit 3, the state guidelines?
A. Correct.
Q. Which were not mandatory --
A. Correct.
Q. -- in your understanding, correct?
A. That's correct.
Q. So the date on this document in the upper right-hand corner, it says, "Original date, 9/20/15." Do you see that?
A. Yes.
Q. And when was the first time you recall seeing this document?
A. I participated in the drafting of the language of this document.
Q. In the upper right-hand corner, it says Policy No. XIV, in Roman numerals, dash, 01. Do you see that?
A. I do.
Q. Is there a significance to the "01"?
MS. SCOLNICK: Object to the scope. But you can answer it.
A. I don't know.
Q. Is this, to your knowledge, the

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first MetroHealth controlled substance prescribing policy?
MS. SCOLNICK: Object to the scope. But you can answer.
A. Not that I'm aware of.
Q. Meaning you're not aware of any prior policies?
A. Correct, I am not aware of prior policies.
Q. So you mentioned that you participated in the drafting of the language in this document, correct?
A. Yes, that's correct.
Q. Can you describe the process for drafting this document?
A. We engaged stakeholders from throughout the hospital who practiced in a variety of health care settings, and we reviewed current policy, both state guidelines as well as state law, and incorporated them into this policy.
Q. And was there a group of people who worked on this?
A. Yes.
Q. Who was in that group?

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A. Dr. Sherrie Dixon Williams participated, and I don't recall other members.
Q. Do you recall approximately how many people?
A. No.
Q. Do you know -- do you know why you were enlisted to help work on this?
A. At the time, Dr. Williams was heading the opioid -- what -- what was our opioid task force, our opioid safety task force, at that time, and I had recently participated in that committee.
Q. And are you referring to the -- so in -- strike that.
In the upper left-hand corner, it says, "Originated by opioid safety committee." Do you see that?
A. Yes, that's correct.
Q. And is -- is that the opioid safety task force you're referring to?
A. It's the opioid safety committee that was present at that time.
Q. And what was that opioid -- what was the -- what was the -- strike it.
What was the purpose of that opioid

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safety committee at the time?
MS. SCOLNICK: Object to the form.
A. To improve opioid safety throughout the hospital system.
Q. When was it launched?
A. I don't know.
Q. Do you know what prompted it to be created?
A. I don't know.
Q. When did you first become involved?
A. Shortly before this policy was created in 2015.
Q. And you said Dr. Dixon Williams was the head of that committee at the time?
A. Yes, that's correct.
Q. Aside from drafting this policy, were there any specific initiatives that the opioid safety committee was working on at the time?
A. I believe there was some educational initiatives to increase awareness of new state laws and -- and guidelines. I don't recall specifics.
Q. And were those educational initiatives directed towards prescribers?

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A. Yes.
Q. Any educational initiatives related to the addictiveness of opioids?
A. I don't recall.
Q. If you take a look at the second page of the document under "General Procedures, A" --
A. Uh-huh.
Q. -- it says, "All licensed prescribers are required by law to register for OARRS in accordance with Ohio state law."
Do you see that?
A. Yes.
Q. What is OARRS?
A. The Ohio Automated Rx Reporting System.
Q. And earlier you had mentioned PMP. Do you recall that?
A. Yes.
Q. Were you referring to OARRS --
A. Yes.
Q. -- when --
And OARRS is a database that prescribers, among other people, are able to query, correct?

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A. That's correct.
Q. And what information in -- in -- strike that.
And OARRS contains information related to prescriptions -- controlled substance prescriptions filled by an individual patient, correct?
A. Yes.
Q. And it's now legally required to check OARRS in certain circumstances, correct?
A. Yes.
Q. Has that always been the case, that it was a legal requirement?
A. No.
Q. Do you know approximately the time when it did become a legal requirement for prescribers to check OARRS?
A. I believe it was just prior to 2015, possibly 2014. I don't remember the exact date.
Q. And so was the -- was the creation of a legal requirement to -- to check OARRS one of the reasons for drafting this policy?
A. We did want to raise awareness and ensure that our -- our providers were

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compliant.
Q. Were there any other reasons that you drafted and issued this policy around September 2015?
A. There was a growing awareness among -- I think nationwide that opioids were becoming a crisis and leading to overdoses, and this -- this became a growing concern among our hospital leadership, and we wanted to take initiative to do as much as we could to raise awareness among our staff.
Q. So you said it was a growing concern in 2015?
A. Yes.
Q. But Cuyahoga County had had an opiate task force for a number of years by that point, correct?
A. That's correct.
Q. Since 2010, correct?
A. I don't know the date that they started. I was not a member until 2012.
Q. But you know at least since 2012, correct?
A. I was aware in 2012, that's correct.

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Q. And you yourself researched and launched Project DAWN to combat the opioid overdoses you were seeing in the emergency room, correct?
A. Yes, that's right. That happened in 2013.
Q. So why in 2015 was it still a growing concern for you and your colleagues?
MS. SCOLNICK: Objection to the form.
Q. Was it a full-blown concern by then?
A. I think the concern began even earlier. It began in the beginning of the 2000s and the mid-1990s. It has continued to grow over time. That wasn't a plateau. It wasn't the beginning. It wasn't the end. It was a growing concern.
Q. Got it. So growing in terms of the trajectory of it?
A. Correct.
Q. Okay. So the magnitude, not the existence?
A. Not the existence, but, yes, the magnitude.

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Q. Got it.
A. I think physicians also were beginning to recognize some of the root causes of -- of the epidemic as well.
Q. And what were those -- and by "physicians," you -- you include yourself in that group?
A. Yes.
Q. So what were the -- were the root causes that you were beginning to identify?
A. An increased -- an increased distribution of opioid prescrip- -- prescriptions. There was a 600 percent increase in the distribution of opioid grams in the state of Ohio over about a decade.
Q. And when you say "increased distribution," do you mean an increased number of prescriptions being filled by pharmacies?
A. Yes, but -- but that would also include medications personally furnished as well.
Q. Personally furnished by prescribers?
A. Prescribers, yes.
Q. So this increased distribution

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reflected an increased number of prescriptions that were being written, correct?
A. Prescriptions and medications that were personally furnished, yes.
Q. And medica- -- medications that are personally furnished by a prescriber, does that prescriber still have to write a prescription in order to personally furnish them?
A. That's not our practice at MetroHealth. We don't personally furnish opioid medications.
I believe at the time there were some outside facilities that personally furnished opioid medications directly to patients. Our institution was not one of those institutions.
Q. Do you currently -- strike that.
So turning back to -- to OARRS for a second.
A. Uh-huh.
Q. So I take it you currently comply, in your practice, with the legal requirements for checking OARRS, correct?
A. Yes, that's correct.
Q. But back before it was a legal

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requirement, did you regularly check OARRS as a part of your practice before you wrote an opioid prescription?
A. Yes.
Q. When did you start doing that?
A. As soon as I was aware that the database was available.
Q. Do you know when the database was created?
A. I think that I registered around 2008 or 2009, but I don't recall the precise date.
Q. And what were the circumstances under which you would check OARRS back in that 2008-2009 time frame?
MS. SCOLNICK: Object to the form.
You can answer.
A. I typically checked OARRS prior to writing any prescription for -- for an opioid.
Q. Why did you do that?
A. We in the emergency department care for a number of patients with substance use disorders, and I was concerned that they may be at risk for developing opioid use disorder or may already have developed opioid use disorder.

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Q. And did you continue that practice of regularly checking OARRS up to 2015 when it become mandatory?
A. Yes.
Q. And you continue to do that today?
A. Yes.
Q. From working in the emergency room, have you developed an understanding of how often your colleagues checked OARRS back in the 2008-2009 time frame when you first registered?
A. I'm sorry. Can you restate that question?
Q. Yeah. So while working in the emergency room in the period of time prior to the legal requirements to check OARRS, did you develop an understanding of how often your colleagues were looking at OARRS?
A. I did.
Q. And how often would they do that?
A. I can't speak to the frequency, but the majority of our providers in the emergency department regularly checked OARRS.
Q. And that was the case even before it was legally required?
A. I believe -- I believe that the

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majority of providers in our department did, although I can't speak to specific providers and I can't speak outside of generalities.
Q. And to your knowledge, are your colleagues in the emergency room complying with the current requirements to check OARRS?
A. To my knowledge, yes.
Q. No reason to believe they are not complying?
A. No.
MS. McNAMARA: What was that?
MS. SCOLNICK: I said it's been about an hour, and I asked if she was getting tired.
MS. McNAMARA: It's up to you.
THE WITNESS: I actually would like to go to the bathroom if that's okay.
THE VIDEOGRAPHER: Off the record, 11:38.
(Luncheon recess.)
THE VIDEOGRAPHER: Back on the record at 12:24 p.m.
BY MS. McNAMARA:
Q. Welcome back.
A. Thank you.

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Q. Before lunch we were discussing the 2015 controlled substance prescribing policy. Do you recall that?
A. Yes.
Q. And that was drafted by the opioid safety committee?
A. Yes, that's correct.
Q. Did you remain involved with the opioid safety committee after the issuance of the policy in September 2015?
MS. SCOLNICK: Objection to form.
A. Yes.
Q. And what did the opioid safety committee do in terms of initiatives or projects after the policy?
A. I -- I recall that we did a few educational events. They also sponsored our full-day conference on the stigma of opioid use disorder.
Q. And for how long did that committee exist after -- strike that.
Is that committee still in existence today?
A. No.
Q. How long did it -- it exist after

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September 2015?
A. I don't know. It did end sometime between 2015 and our opioid safety task force. There was a gap.
Q. Earlier today you described the policy as mandatory, correct?
A. Yes.
Q. Were you aware of MetroHealth monitoring prescribers' compliance with the policy in any way?
MS. SCOLNICK: Object. Beyond the scope.
You can answer.
A. Can I take a moment to think about that? I'm not sure that I -- I don't know. I'm not aware of any monitoring that was occurring in that immediate time frame.
Q. In the 2015 time frame?
A. In 2015. I was not in a leadership role at that time. There may have been efforts or whatnot that I was not participating in.
Q. Do you receive any performance reviews as a staff physician at MetroHealth?
A. Yes.
Q. And as -- as part of your

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performance review, the review process, was compliance with the controlled substance prescribing policy considered?
A. No.
Q. Do you know whether there was any penalty for not complying with the controlled substance prescribing policy?
A. Not to my knowledge.
Q. So over the past couple of years, MetroHealth has undertaken a number of initiatives to reduce opioid prescribing, correct?
A. Yes.
Q. And when we're talking about reducing opioid prescribing in terms of MetroHealth's initiatives, is the focus on reducing the number of prescriptions?
MS. SCOLNICK: Objection as to the scope. She can answer.
A. We monitor a variety of metrics, including the number of prescriptions.
Q. And do you also monitor the number of pills?
A. Yes.
Q. And is this part of the work of the

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opioid safety committee?
A. No.
Q. Who does the monitoring of the number of prescriptions and pills?
A. That initiative was led by our opioid executive committee. Initial work was started in our controlled substance peer review committee, but that work accelerated when we formed the opioid executive committee.
Q. So just so I get the committee names straight, so initial review by the controlled substances peer review committee?
A. Yes.
Q. And then it escalated to the opioid executive committee?
A. They're separate committees.
Q. Yes.
A. The controlled substance peer review committee formed -- I don't want to --
Q. Yeah.
A. -- hold -- hold you to the date --
Q. I will --
A. -- be held to the date, but I think it was in 2016 that committee formed.
And we did an analysis of

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prescribing metrics, and we had a greater level of sophistication of our analysis when our opioid executive committee formed. That committee formed in 2- -- the end of 2017. We had an analy- -- analyst -- excuse me -- that was dedicated to obtaining that data for us.
Q. And are you on the opioid executive committee?
A. Yes.
Q. How many members are on that committee?
A. It varies. We have ad hoc members and regular members, but between 10 and 15.
Q. And is that 10 to 15 total, ad hoc plus regular?
A. I -- I couldn't --
Q. Do you happen to know how many regular members there are?
A. I don't know. May- -- maybe ten. Eight or -- maybe eight or ten.
Q. And the -- the analyst that you mentioned with respect to the opioid executive committee, is that someone that was hired?
A. No.
Q. It was someone who was already

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employed by MetroHealth?
A. Yes.
Q. Who is that person?
A. Peter Lawson.
Q. Who was responsible for deciding that MetroHealth should try to reduce the number of opioid prescriptions?
MS. SCOLNICK: Object to the scope.
A. I think that the work that we did with the controlled substance peer review committee sparked an interest in reducing the number of opioid prescriptions and other opioid-prescribing metrics, but it became formalized, and goals were set when leadership became involved.
Q. And when you refer to leadership, who -- who are you referring to?
A. Dr. Boulanger, the chief clinical officer at the hospital.
Q. Now, this -- these strategies to reduce opioid prescribing, this is not a result of MetroHealth determining that its prescribers were writing illegitimate prescriptions --
MS. SCOLNICK: Object as to --
Q. -- right?

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MS. SCOLNICK: Object as to form.
A. No.
Q. To your understanding, it's about the evolving knowledge of the addictiveness of these drugs, correct?
A. And -- and the evolving knowledge of the adverse outcomes associated with them. So not just addictiveness, but also fatalities associated with them. And other associated morbidity, I should add.
- - - - -
(Thereupon, Deposition Exhibit 5, 4/18/2017 The MetroHealth System Opioid Committee Meeting Minutes, MH000000566 to 000000567, was marked for purposes of identification.)
- - - - -
Q. Going to hand you Exhibit 5.
A. Thank you.
Q. Exhibit 5 is Bates-labeled MH000000566.
Do you recognize this document?
A. I do.
Q. What is it?
A. It is the minutes from our

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controlled substance peer review committee.
Q. And this is the same committee that was launched in 2016?
A. Yes.
Q. Okay. And the minutes indicate that you were -- you were the chairperson?
A. Yes, that's correct.
I would add that at the top it says "Opioid committee." This is -- this is peer review.
Q. Okay. Does the peer review committee meet regularly?
A. Yes.
Q. How often?
A. We try to meet monthly. Sometimes meetings get canceled, but typically monthly.
Q. Have you been the chairperson since the committee was started in 2016?
A. Yes.
Q. Do you have an understanding as to why it was started?
A. We had a growing concern that patients may be at risk for adverse outcomes from opioid prescriptions.
Q. And what was the purpose of the

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committee? What -- strike that.
The -- the committee still exists, correct?
A. Yes.
Q. So what's the purpose of the committee?
A. The committee serves to review opioid-prescribing patterns to determine if there are any outlying prescriber patterns, and to reeducate providers if we identify providers who may be prescribing in a manner that is -- that varies from their peers or does not appear to be consistent with guidelines.
Q. So does the committee -- does the committee review the prescribing patterns of all prescribers employed by MetroHealth?
A. We review prescribing data from all prescribers. We don't do in-depth reviews of all providers.
Q. Got it.
And what prescribing data does the committee review?
A. We look at total prescriptions of an opioid, a C2 prescription. We look at total pills prescribed by that -- by pro- -- by

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providers. We look at average MME. We also look at opioid prescriptions co-prescribed with a benzodiazepine. And there may be other metrics I am not recalling, but those are the main ones.
Q. And you mentioned "average MME." What is "MME"?
A. Morphine milligram equivalent.
Q. And what's the significance of that metric?
A. With increasing MME, there's an increased risk of adverse events, including overdose.
Q. And is it fair to say that the -- the higher the MME, the stronger the dosage?
A. Yes.
Q. Just trying to --
A. Yes.
Q. Fair, in layman's terms?
A. Yes.
Q. Okay. And you also mentioned co-prescribing of opioids and benzodiazepine, correct?
A. Yes, that's correct.
Q. So what's the significance of that

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metric?
A. It increases the risk for respiratory depression and other adverse events.
Q. And just what are some common benzodiazepines? Just to -- for a background in case we play this for the jury.
A. Sure. Valium, Ativan, Xanax.
Q. And so after you review the prescribing data for everyone, do you select certain providers for a more in-depth review?
A. Yes.
Q. And how -- how do you select those providers?
A. We review providers who appear to be prescribing at a higher rate on those metrics compared to either their peers or overall throughout the hospital.
Q. And when you say "peers," what are you referring to?
A. We compare providers both to other providers that are practicing in the same practice environment, as well as overall, compared to all providers within the hospital system.

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Q. So, for example, if someone practices in the palliative care area, you would compare them both to other palliative care providers and then to other providers?
A. Yes, that's correct. It wouldn't be fair to compare a palliative care physician to a pediatrician.
Q. Because you'd expect a palliative care provider, just because of the nature of the practice, to prescribe more opioids?
A. Yes, that's correct. They have a different patient population.
Q. So going to the minutes of this particular meeting -- and actually back up.
Do you recall attending this particular meeting?
A. Yes.
Q. In the lower left-hand corner, there's a reference to the "pain board." Do you see that?
A. Yes.
Q. What's the pain board?
A. This was a planned initiative to create a group of physicians to review complicated medical patients who are being

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treated with opioids. This board did not form. We never created this forum.
Q. And was it an internal MetroHealth initiative?
A. It was an initiative of this -- it was a -- it was a planned initiative for this group that didn't get off the ground.
Q. Why didn't it get off the ground?
A. Other -- other initiative took precedence. At that time I didn't have a -- a staff. It was me running the show.
Q. Because this is in April 2017, correct?
A. This is in April of 2017.
Q. So this is before the launch of the Office of Opioid Safety?
A. It's before the launch of the Office of Opioid Safety, and it was before we were -- we received numerous grant funds that required our immediate attention.
Q. So what initiatives did you prioritize over the pain board at the time?
A. We prioritized initiatives to train our physicians to obtain their DEA waiver. We prioritized a conference to educate our

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prescribers on safe opioid prescribing. I think that's mentioned here in this minutes as well. We also prioritized the simulation program for safe -- safer prescribing.
Q. And what's a DEA waiver?
A. It is a waiver that allows a prescriber to treat opioid use disorder with opioid agonists.
For clarification, in this document that training is referred to as MAT training, medication-assisted treatment training. It can be kind of used interchangeably, but "DEA 2000 waiver" is the correct terminology.
Q. Got it.
And the conference you're referring to, is that the SCOPE of Pain discussed in this document?
A. Yes, that's correct.
Q. And what was the simulation program that you were describing?
A. It is an ongoing program that is managed by our simulation center that involves actors who act out a particular script regarding opioid prescribing so that a physician can walk into a room, have a

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conversation with a patient about, you know, one of a number of topics that we developed. Prescribing opioids to a patient that they had inherited on high doses of opioids was one of the topics. Responding to a patient who had an abnormal toxicology screen was another topic.
Q. And were you involved in selecting the scenarios for the simulation?
A. I was not the lead on this project, but I was involved.
Q. Was there a written script for these?
A. Yes.
Q. Were you involved in the drafting of the script?
A. Not involved in the drafting, but involved in the review.
Q. And the simulation program did get off the ground, correct?
A. Yes.
Q. When did that start?
A. I don't recall. Shortly after this -- this meeting.
Q. And it's still going?
A. Yes.

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Q. In the context of the pain board, it references -- in the fourth line -- third and fourth line, it says, "Dr. Margolias discussed the draft algorithm from the opioid advisory committee put together to create the algorithm to put together the pieces to support the algorithm."
Do you see that?
A. Your guess is as good as mine.
Q. Do you know what algorithm they're referring to?
A. Again, this -- this project never got off the ground. You know, we discussed initiatives. We sort of do brainstorming. At -- at this time there was no other opioid group, so we were doing some brainstorming about how we could develop a group or a forum like this, but there -- there must have been some algorithm that we were trying to -- trying to sort out that never happened.
Q. Got it.
On the flip side of the document, on page --
A. Uh-huh.
Q. -- 2, it discusses a review of a

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provider. Do you see that?
A. I do.
Q. And this particular provider is a palliative care provider, correct?
A. Yes, that's correct.
Q. And it says that the provider was reviewed by E. Horwath, correct?
A. Yes.
Q. Who is that?
A. He's the chairman of psychiatry.
Q. Okay. And when the committee looks at the prescribing data and identifies specific providers to look at more closely, about how many providers do you identify at a time?
A. We had different practices when we first started our program. And we looked at providers that had the highest metrics initially. And we were somewhat limited because intensive reviews are very lengthy and physicians really didn't have the time allotted to spend the several hours that it would take to do a deep-dive review, so we prioritized the providers who had the highest metrics.
Q. And how many providers did you identify in that initial cut?

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A. I don't recall.
Q. And so with a -- with a palliative care provider, as I think we said before, you expect a higher level of opioid prescribing relative to other specialties like pediatricians, correct?
A. Correct.
Q. So the fact that a palliative care provider has a higher rate of opioid prescribing than other specialties does not, in and of itself, make that person an outlier, right?
A. Not necessarily.
Q. So in the -- in the description of the recommendation and action here, it says that "There was a discussion of the severity of illness of each patient." Do you see that?
A. What line are you looking at?
Q. Oh, I'm sorry. In the first full paragraph, the second to the last line, it says, "Severity of illness for each patient was discussed."
A. Yes.
Q. Do you see that?
A. Yes.

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Q. And is that typical of the review process, that you look at each individual patient?
A. We look at the diagnosis associated with the prescription.
Q. Why is that important?
A. To determine -- to -- basically to put it in context, to put the prescription in context.
Q. Because some patients, depending on their condition, might require higher amounts of opioids to relieve their pain?
A. It's specific to the patient, but in general terms, yes.
Q. And, for example, there's a -- the next sentence in the review says, "Spinal cord injury patient had the most prescribing."
Do you see that?
A. I do.
Q. So that's an example of a person who might need considerably more opioids than the average patient?
MS. SCOLNICK: Objection to the form.
A. Depends on the context. I don't

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have the detailed information regarding that patient's case.
Q. But some patients might legitimately require high volumes of opioids, fair?
MS. SCOLNICK: Objection to the form.
A. Again, I would -- I would say that it depends on the individual case of the patient. And the time frame: acute versus chronic.
Q. In terms of the review of the individual diagnoses of the patients, is that performed by a single physician?
A. No.
Q. How many people participate in that review?
A. In this process that we had in place at the time of these minutes, a provider was chosen based on the metrics that we reviewed, and then 10 patients were chosen, and those patients were chosen based on the dosage, or the MME, that they were prescribed. And those individual patients were -- much more intensive evaluation and review of those

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patients' medical charts was completed.
And the items that we reviewed included the -- the diagnosis, the other medical diagnoses that patient had, the other medications that they were taking. And we evaluated whether they were compliant with a number of basic opioid stewardship measures.
We tried to determine based on the chart review, but the next step was to meet with the -- the provider and get additional information, because sometimes we don't get the full picture without having a conversation with the doctor.
Q. Got it.
So if I'm understanding correctly, the -- the review of the 10 patients was conducted separately, and then there was a conversation with the doctor --
A. That's correct.
Q. -- to resolve any questions?
A. Right.
Q. And in the last paragraph in the minutes, it says, "After a meaningful discussion, Dr. Horwath and J. Papp will meet with this provider after the next review."

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Do you see that?
A. Yes.
Q. And is that -- is that the conversation that you've just described? The type of conversation?
A. Yes. That -- that resulted from our peer review meeting discussing Dr. Horwath's review of the 10 patients, and the committee decided that based on his review of those patients, that Dr. Horwath and I would meet with the provider in question.
Q. You mentioned that one of -- one part of the review is determining whether the compliant -- whether the prescriber is compliant with opioid stewardship measures?
A. Yes.
Q. What were you referring to by "opioid stewardship measures"?
A. Were they complying with CDC guidelines? Were they documenting that they had queried OARRS and documenting a summary in the medical record?
There were a number of other items that are just not coming to my head right now. Were they co-prescribing naloxone, was another

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one. But that's part of the CDC guidelines.
Q. And do you recall actually having a subsequent meeting with this provider?
A. Yes.
Q. And what was the result of that meeting?
A. I believe that's subject to peer review confidentiality.
MS. SCOLNICK: Sorry.
Q. Let me ask that --
MS. SCOLNICK: Yes, it is.
Q. Okay. So let me ask a more targeted question.
Was -- was this provider disciplined as a result of the review?
A. No.
Q. So is it --
A. And I -- and I should clarify that this is not a disciplinary committee.
Q. Yeah.
A. This is a peer review committee.
Q. So, yeah, my next -- is it fair to say that the peer review process is intended more to educate providers --
A. Yes, that's correct.

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Q. -- than to discipline them?
A. Yes.
Q. Okay. That makes sense.
A number of the documents mention Epic. Are you --
A. Yes.
Q. -- familiar with Epic?
A. Unfortunately, yes.
Q. What is Epic?
A. It's our electronic health record.
Q. Is Epic an acronym for something?
A. Not that I know of.
Q. Okay.
A. I don't think so.
Q. How long has MetroHealth used Epic?
A. As long as I've been at MetroHealth.
Q. Since at least 2007?
A. Since 2000. I trained at Metro as well. It's been there.
Q. So I take it Epic has evolved over the years?
A. It has. It's become more sophisticated.
Q. Have there been any features added

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to Epic that relate specifically to opioid prescribing?
A. Yes. Features that we added.
Q. You, as in the Office of Opioid Safety?
A. As in members of our opioid executive committee. I guess in our opioid safety committee as well, yeah.

- - - - -

(Thereupon, Deposition Exhibit 6, Slide Deck Titled, "Metro Health Office of Opioid Safety," CUYAH_002048327, was marked for purposes of identification.)

- - - - -

Q. I'll hand you Exhibit 6. Exhibit 6 is Bates-numbered CUYAH_002048327.
Do you recognize this document?
A. I do.
Q. What is it?
A. It is a PowerPoint presentation -- I don't know the -- I don't know who the audience was -- that I put together to give an overview of the Office of Opioid Safety, our mission, and some of our goals.

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Q. So if you turn ahead -- I don't think we have page numbers. There's a slide with the title "Provider Resources" at the top. I think it's the seventh page in.
A. Oh, yes.
Q. And the first item listed here is "Epic Support," correct?
A. Yes.
Q. And it lists an MME calculator, order sets/smart sets, best practice alerts, and links to resources and handouts, correct?
A. Yes.
Q. And are these some of the upgrades that the opioid executive committee implemented to Epic?
A. These are examples of some of the resources that we created.
Q. So what is an MME calculator?
A. There are two forms of an MME calculator that we have created in Epic.
And just for clarity, we have an informatics specialist who creates these for our Office of Opioid Safety. He actually is employed, not in our Office of Opioid Safety, but he's employed in the office of -- the

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informatics department. But his role is to create resources in Epic to make safer prescribing easier for providers.
The MME calculator, again, it comes in two forms. We have a total MME calculator that puts the total MME of prescribed opioid medications in what we call the header in Epic, which is the top line of the screen that shows the patient's name, date of birth, medical record number, allergy and vital signs. And right next to that is total MME, and that's a calculation of all the opioid MMEs there are in Epic. That's one area where we have a calculator.
I think since we built this -- or since I wrote this presentation, we've also created a second in-line calculator, so that when a prescriber is writing a prescription, before that prescriber signs the prescription, they can see what the total MME of that prescription is equal to.
Q. And when did the total MME calculator in the header become available?
A. 2017, I believe.
Q. And the in-line calculator was --

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A. It came much later. Either -- either late 2017 or early 2018. I can't remember.
Q. It also references order sets and smart sets. What are those?
A. Order sets are standard -- it's a -- sort of like a -- I guess the best way I could describe it would be a list of common orders that a physician may prescribe together.
For instance, if I were admitting a patient, I may want to order meals, activity level, prescriptions, and an order set gives you a list of options from which to choose from. And there are standard defaults for medications, including dosages, as well as total pills dispensed.
Q. So it -- it helps the physicians decide on a dosage?
A. It standardizes and simplifies the ordering process.
Q. And how does that help -- or, scratch that.
Does that help reduce opioid prescribing?
A. If done with that intent, it can

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reduce opioid prescribing.
Q. What do you mean by "if done with that intent"?
A. Some of the specific initiatives that we took were to reevaluate some of the order sets and change the order sentence and the default quantity prescribed.
For instance, as an example, if we saw a prescription for one tablet every four to six hours with a 30-tablet default, that was changed to one tablet every six hours with a default option of three-, five-, or seven-day supplies.
Q. Got it.
How long have there been order sets in Epic?
A. As long as I remember, which would be since it started in, I guess, 2000.
Q. But then there were recent adjustments to the default sets for some opioids?
A. Yes, that's correct.
Q. And when did that occur?
A. Over the course of, boy, mostly in 2018. Probably some of that work happened in

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2017 as well, with that calculator and some of the other things that we did.
Q. Were there any adjustments made after the issuance of -- after Ohio issued the acute prescribing guidelines --
A. Yes.
Q. -- for opioids --
A. Yes.
Q. -- back in 2012?
A. Oh, I --
Q. Yes.
A. I apologize. I thought -- I thought you were referring to the acute pain rules --
Q. So let me -- let me back up --
A. -- not the guidelines.
Q. -- so we have a clear record.
So do you recall, earlier, we reviewed Ohio guidelines for opioid prescribing in the acute care and emergency setting?
A. Yes.
Q. And one part of those guidelines was that opioid prescriptions should not exceed three days, correct?
A. I don't think that's exactly --

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Q. Okay.
A. -- what those rules say, but --
Q. Generally speaking it should be limited to three days or less? You're welcome to --
A. We can -- we can --
Q. Yeah, go for it.
A. -- can -- just for the record clarify exactly --
Q. Sure.
A. -- how it's worded.
Q. Because I can't find mine.
A. "Except in rare circumstances, prescriptions should be limited to a three-day supply."
Q. Were any changes made to the order sets after that guideline was issued?
A. No.
Q. Another of the provider resources are best practice alerts.
A. Yes.
Q. What are those?
A. Those are alerts to a provider when an order is being placed to remind them of current guidelines and other best practice.

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Q. And so best practice alerts were created for opioid prescriptions?
A. Yes.
Q. And what guidelines did they reference or incorporate?
A. We included an alert for -- in an ambulatory environment, we set an alert so that if opioid prescribing exceeded 80 MME, that an alert would fire, reminding the provider that that was a high dose of a medication.
That same type of warning was also set to fire in acute settings, but the threshold was lower. It was set at 30 MME, and that was to comply with state law.
Q. And in the -- in the ambula- -- strike that.
"Ambulatory environment," what does -- what does that mean?
A. That means the outpatient setting. Generally primary care, specialty clinics.
These are well patients who are coming for a doctor visit, as opposed to acute care where they're injured or having an acute crisis.
Q. And the best practice -- the best

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practice alert in the ambulatory environment for over 80 MME, when was that set?
A. That was set probably in 2017 or 2018.
Q. And was the acute warning for the 30 MME set around the same time?
A. Yes, I believe so.
Q. How long has Epic had the capability of doing the best practice alerts?
A. I'm not an informatics specialist. I can't answer that.
Q. Has -- so in -- in your practice, have you received best practice alerts through Epic when you've prescribed medications?
A. Yes.
Q. What's the earliest you can recall receiving one?
A. I don't recall. Probably within the last 10 years.
Q. But they definitely existed prior to 2017-2018, when the specific alerts for opioids --
A. Yes. When we created those, yes.
Q. And the last provider resource is the links to research and handouts. Do you see

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that?
A. Yes.
Q. And what type of resources and handouts is Epic linked to for opioids?
A. We have links that when you -- it would be nice if I could do a demo, but when you click on the MME in the header, you get a list of links. Those -- because when you click on the MME in the header, first you get a drill-down of how the prescriptions were calculated to create that MME total that's in the header, and then below that are a list of links, sort of a resource guide that we created to provide access to CDC guidelines, and on the CDC website there's a number of handouts, so we link to several of those.
Also link to state and other rules and medical board rules there. We tried to put all the kind of common resources the doctors might want to have access to in one place.
Q. Underneath the Epic support and the provider resources slide, it mentions pain management boards. Do you see that?
A. I think I've lost my page. I'm sorry. I should have numbered these.

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Yeah, again, this was -- this was one of our planned initiatives that just didn't get off the ground.
Q. Got it. So the same pain board we --
A. The same thing, yeah.
Q. -- discussed earlier? Got it.
So if you flip ahead about three slides, there's one with a heading "Predictive Analytics." Do you see that?
A. Yes.
Q. And it says, "Use system data to identify patients or providers who may benefit from a specialized care pathway."
Did I read that correctly?
A. Yes.
Q. And what system data is this referring to?
A. This is the prescribing data that we reviewed with our analytic -- with our analysts.
Q. And this prescribing data is stored, I take it, in some sort of database at MetroHealth?
MS. SCOLNICK: Object to the form.

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A. It's stored in a secure file, in a secured database, yes.
Q. And MetroHealth has been compiling and storing prescribing data for as long as you worked there, correct?
A. I --
MS. SCOLNICK: Object to the scope.
A. -- can't speak to any of the work that MetroHealth did prior to my involvement.
Q. So when did you first become aware that MetroHealth had stored prescribing data for the physicians it employs?
A. I guess when we started our controlled substance peer review committee. That's when I requested the data.
Q. And when you requested the data, did you request data from -- did you request prescribing data from previous years?
A. Yes.
Q. How far back did you request?
A. I don't recall. Probably no more than a year prior to our controlled substance peer review committee formation.
Q. Why not go back farther?
A. Many physicians had changed their

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practice, and it didn't seem pertinent to re-educate providers who had clearly already changed their practice.
Q. And I know we spoke about your -- your personal evolving understanding, but how did you come to realize that many other people -- many other physicians had also changed their practice?
MS. SCOLNICK: Object to the form.
A. We reviewed data over time, and we noticed a trend towards decreasing opioid metrics on a number of the metrics that we reviewed.
Q. So the "we" is the controlled substance peer review committee?
A. That committee, as well as our opioid executive committee. Again, when we started our controlled substance peer review committee, we had limited resources available to us to analyze data. It became much more sophisticated in later years.
Q. So when you were reviewing data over time, what specific data were you looking at that you were just referring to?
MS. SCOLNICK: Object to the form.

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A. The same data we -- we discussed before. Total -- total opioid prescriptions, total opioid prescriptions per encounter, total opioid pills, average MME, opioids plus benzodiazepines, and there may be some other measures that I'm failing to recall.
Q. And how far back did you look in that analysis?
MS. SCOLNICK: Objection.
A. Our initial analysis?
Q. Yes.
A. Again, one year prior to the formation of our committee is as far as back as I recall that we looked.
Q. I think -- my question was bad, and I'm sorry.
A. That's okay.
Q. So you had said that many physicians changed their practice, and you said you understood that through a review of data over time.
A. Well, and we noticed that prescribing patterns were changing, and that was generally something that we expected would have happened across the system, although we

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didn't -- may not have had any hard data to prove that.
And it generally doesn't make sense to go too far back because, you know, physicians' behavior and practice patterns evolve over time with new information, and so we thought it was pertinent to look one year prior to the time of our committee formation.
And we had limited resources at the time as well. We didn't have an army of physicians who were able to do these reviews. So it's a very time-intensive process.
Q. So have you ever looked at the prescribing data back, say, to 2007 when you started and analyzed that trend?
MS. SCOLNICK: Objection. That has been asked and answered.
You can answer again.
A. I'm not --
Q. So separate and apart from the analysis you just described, have you ever looked at prescribing data going back farther than a year, to say 2007, to get a -- a longer-term trend?
A. If there were an individual patient

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who we were reviewing, we would do a detailed chart review that may go back several years. But we did not look system-wide or provider-wide at -- at metrics, but we did go back and look on individual patients several years prior.

Q. Got it. Okay.

And if you flip forward another four slides, there's a slide titled "Study and Report Outcomes." Do you see that?

A. I do.

Q. And to put this in context, this PowerPoint was written at the launch of the --

A. Correct.

Q. -- opioid safety committee, correct?

A. Correct. Right. It was -- right.

Q. So these are -- are goals at the --

A. These goals -- proposed.

Q. -- start of the program?

A. These were proposed outcomes that we planned to look at. Some of them we looked at. Some of them we did not. Sometimes we found better measures that we felt were worthy of looking at instead.

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Q. Have you looked at -- the first item on the list is, "Reduce total average MME throughout the system." Do you see that?

A. Yes.

Q. And is that a metric you've looked at?

A. Yes.

Q. And have you reduced the total average MME throughout the system since the Office of Opioid Safety was launched?

A. It depends on how you look at it. So overall, I will say yes.

Q. And why does it depend on how you look at it?

A. Because we have -- we look at data system-wide, and we look at data based on each department. System-wide, the MME has decreased. Most departments have also decreased the average MME. There are, however, individual providers whose average MME have not changed.

Q. The second item on the list is, "Reduce percentage of opioids per encounter." Do you see that?

A. Yes.

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Q. What does that mean?

A. We looked at not only total number of pills, but total number of pills per patient encounter. Because opioid prescribing is not -- you know, different -- different providers have -- see different volumes of patients and have different numbers of encounters that they participate in, and so a rate is a better way to equalize that M- --

Q. So -- so it's basically a rate of prescribing per patient seen?

A. Correct.

Q. Okay. And is that a metric you've looked at?

A. Yes.

Q. And have you reduced the -- the percentage of opioids per encounter?

A. Again, system-wide we have reduced that rate. There are individual providers who have not reduced their rate.

Q. And these individual providers who haven't changed MMEs or reduced their rates, do you, as the director of the Office of Opioid Safety, consider that to be problematic?

A. Yes.

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Q. Why?

A. That indicates that they have not responded to the education that we have provided.

Q. And are you -- so you've been able to identify these people, I take it?

A. We have a -- a few providers who have not responded.

Q. And are you taking any action or directing any other initiatives toward those specific providers?

A. Yes.

Q. What are you doing?

A. We have provided additional resources for them, including a second meeting, to inform them of their progress or lack of progress.

We have required that they participate in educational events. I -- actually, I to want retract that. We have recommended. We don't require. We have recommended that they participate in educational act- -- educational activities, and we have offered to pay for those activities.

We have also recently hired a pain

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management pharmacist to work directly with those providers to provide them additional resources and support.
Q. Does the Office of Opioid Safety have the power to discipline physicians?
A. No.
Q. Notwithstanding their -- notwithstanding the fact that they haven't reduced their opioid prescribing, do you have any reason to believe that these providers are writing illegitimate prescriptions or not performing a risk-benefit analysis --
MS. SCOLNICK: Object to the form.
Q. -- before prescribing an opioid?
MS. SCOLNICK: Object to the form.
A. No.
Q. The next -- the next item on the list is, "Improve OARRS documentation."
A. Yes.
Q. Have you looked at that?
A. We have.
Q. And has OARRS documentation improved?
A. We have a very limited measure of evaluating OARRS documentation. Many providers

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write in their own documentation that they've checked OARRS. We created a smart phrase that we can query and run reports on, but compliance is difficult. And many providers choose to write in their documentation of OARRS, and so we have a very rough estimate of their compliance with OARRS.
You may know that the pharmacy board does not allow us to measure compliance of our providers. We have no -- no way to get a report on who is checking OARRS. So we rely on the documentation. But that has improved.
Q. Okay. So this is providers' self-documentation of checking OARRS?
A. Yes, providing a summary of what was seen in the OARRS database.
Q. And based on the information you have, what's the percentage of times pharmacists check OARRS?
A. Times pharmacists check OARRS?
Q. Actually, strike that.
So what is the -- what is the metric that you maintain with respect to OARRS documentation?
A. The only report that we are able to

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run is a report on the use of the "dot OARRS" phrase.
Q. Okay. So you can see how many times that was run per opioid prescription -- over the number of opioid prescriptions?
A. We can associate -- we can associate that with the times that an opioid prescription was written during the same encounter. And so it's a rough estimate of compliance, simply because checking OARRS is not required with every prescription, and so a provider may be in compliance with the law and have written the prescription, but our report wouldn't give us that detailed information.
Q. And what's -- what's the rough estimate?
A. System-wide?
Q. Yes.
A. I don't recall off the top of my head.
Q. System-wide, have you looked at whether there's been a decrease of prescribing of opioids plus benzodiazepines?
A. There -- it has remained relatively stable. But it's a very, very small percentage

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of opioid prescriptions that are written with a benzodiazepine to begin with, so it's very hard to make movement in that metric, and we can only query when an opioid is prescribed at the same time as the benzo prescription.
Q. The next item is a "Decrease of opioid refills within visits of less than six months." Do you see that?
A. I do.
Q. Is that something you've looked at?
A. Oh, I -- it was worded strangely.
So I don't think we run any reports on this, but generally when we review a provider, we want to see that that provider is having a face-to-face encounter with the patient at least every -- now we look at it every three months. We expect providers to see a patient, who is on chronic opioid therapies at least, face-to-face at minimum every three months; ideally, more frequently.
Q. Have you looked at the next item on the list, "Compliance with education/REMS"?
A. Yes, we have looked at that.
Q. What is REMS?
A. Risk evaluation and mitigation

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strategy.
Q. And has compliance with education and REMS increased since the Office of Opioid Safety was launched?
A. Yes.
Q. And what information are you looking at to draw that conclusion?
A. So we have performed, you know, over 100 opioid safety town halls for providers throughout the system, and we measure compliance.
For REMS we only require this to be completed for providers who -- and again, I should back up and say we never require this for our providers; however, we recommend that providers participate in the REMS activity if they prescribe long-acting, controlled-release substances, but we -- we don't require it.
The only means that I have of ensuring compliance is with providers who we have offered to pay for their course, or if they attended our SCOPE of Pain course that was live.
Q. And that's what you're looking at when you say compliance with education --

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A. Yes.
Q. -- has increased?
A. Yes.
Q. The next item is, "Increase total MAT providers"?
A. Yes.
Q. Have you looked at that?
A. Yes.
Q. And has the number of MAT providers increased?
A. Yes.
Q. And the last metric is, "Reduce opioid-related deaths." Do you see that?
A. I do.
Q. And I assume that's something you have looked at?
A. We've looked at countywide data. It's difficult to tie those back to MetroHealth patients, but.
Q. So have you looked at MetroHealth specifically?
A. We have attempted to identify overall opioid deaths that had an encounter at MetroHealth, yes.
Q. And what has the result of that

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been?
A. What specifically are you --
Q. Have you had -- has there been a reduction in the number of opioid-related deaths?
A. I can't answer that.
Q. In general or attributable to efforts by your team at MetroHealth?
A. I -- I don't have an answer to that question.
Q. Got it. Okay.
Have there been -- strike that.
- - - - -
(Thereupon, Deposition Exhibit 7, Document Titled, "Safer Opioid Prescribing for Healthcare Providers," MH000000131 to 000000157, was marked for purposes of identification.)
- - - - -
Q. I'll hand you Exhibit 7.
A. Thank you.
Q. This has a Bates label MH000000131.
MS. HOSMER: Could you repeat that Bates, please?

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MS. McNAMARA: Oh, sure. MH000000131.
MS. HOSMER: Thank you.
Q. Have you seen this document before?
A. Yes, I have.
Q. And this is a PowerPoint titled "Safer Opioid Prescribing for Health Care Providers" --
A. Right.
Q. -- correct?
Did you draft this PowerPoint?
A. Yes.
Q. And do you recall the date or a general time frame of this?
A. When it was drafted?
Q. Yes.
A. The end of 2017. It may have been updated. This looks like an updated version that occurred in 2018.
Q. And what was the purpose of this PowerPoint?
A. This was the opioid safety town hall that was delivered to providers throughout the MetroHealth system that was mandatory.
Q. And I think you mentioned having

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held a hundred town halls or so?
A. Somewhere in -- somewhere in that neighborhood.
Q. And at each of them you would have given a presentation like --
A. Yes.
Q. -- Exhibit --
A. Seven.
Q. -- 7? Yes.
A. Yes.
Q. Okay. I want to look at the slide with the Bates number in the lower right corner ending in 134.
A. Okay.
Q. It says, "Why is safe opioid prescribing important?" Do you see that?
A. Yes.
Q. And at the top it says, on the left, "Patient safety," and then on the right, next to a bullet point, "Unsafe prescribing is driving the opioid crisis."
Do you see that?
A. Yes.
Q. And is that something you wrote?
A. Yes.

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Q. What did you mean by that?
A. I meant that prescribing that was not compliant with current CDC guidelines.
Q. So not prescriptions that were not written for a legitimate medical purpose; just prescriptions that did not comply with the current guidelines?
MS. SCOLNICK: Object to the form.
A. In this context, it refers to prescriptions that were not compliant with CDC guidelines.
Q. And underneath that is a second bullet point that says, "37 percent of overdose deaths from prescribed opioids annually."
Do you see that?
A. I do.
Q. And when it says "from prescribed opioids" -- "overdose deaths from prescribed opioids," was is that figure referring to? 37 percent of what?
A. My references are listed at the bottom. I don't recall which source -- which of those sources I used to obtain that number.
Q. Do you know whether that 37 percent figure refers to overdose deaths where only a

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prescription opioid was present?
A. I don't believe that that was specified in those articles.
Q. So you're not sure one way or the other?
A. I don't know, no.
Q. And then I'd like to look at the slide with the Bates number ending in 136, which has a "Heroin Risk Continuum." Do you see that?
A. Yes.
Q. And did you create this "Heroin Risk Continuum"?
A. I did not.
Q. Where did you get it?
A. These two slides were borrowed from the medical examiner's presentation. I believe Hugh Shannon was the creator of this -- these two slides.
Q. From the Cuyahoga County Medical Examiner's Office?
A. Yeah. Yeah, it says, "Source: Cuyahoga County Medical Examiner's Office."
Q. Okay. So the -- the "Heroin Risk Continuum" at the top of the page kind of

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contains a schematic where on the right we have a person not using heroin, then there's an auto accident, and then there's a previous legal prescription for opioids. Do you see that?
A. I do.
Q. And then the next step on the continuum is using heroin. Do you see that?
A. Yes.
Q. But in your experience, not everyone who receives a legitimate legal -- or strike it.
In your experience, not everyone who receives a legal prescription for opioids after being in an auto accident goes on to use heroin, correct?
MS. SCOLNICK: Object -- object to the form.
A. No, not everybody.
Q. And is it fair to say that in your experience -- strike that. Strike that.
So is it fair to say that in your experience most of the people who go from a previous legal prescription for opioids to using heroin had first abused prescription opioids in some way --

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MS. SCOLNICK: Object to the form.
Q. -- as opposed to using them only as prescribed?
A. Based on medical literature that I've reviewed, the number varies between about 75 and 80 percent of individuals reported a previous opioid that was prescribed prior to starting heroin.
Q. But that 75 to 80 percent figure, does that look at a -- the temporal link between the opioid prescription and the heroin?
MS. SCOLNICK: Object as to form.
A. I'm not -- I don't believe that that was studied in the papers that I've reviewed.
Q. So that 75 to 80 percent figure could include somebody who got a legitimate prescription for opioids in 2013, started using heroin in 2018, correct?
MS. SCOLNICK: Object -- object as to form.
A. I would have to do additional review of medical literature to give you an accurate answer.
Q. But in your exper- -- but I think

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my -- my question, I think, was a little bit different, because I asked in your experience and based on your reading of the literature, is it fair to say that most of the people who go from a legal prescription to heroin first abuse the prescription by taking it other than as medically directed, by diverting it, or some other means?
MS. SCOLNICK: Object to the form and also the scope.
A. I don't know that I can answer that question.
Q. If you flip ahead to 140, it says at the top of the slide "Prescription Opioid Abuse and Heroin." Do you see that?
A. Yes.
Q. And in the left-hand column, it says, "Up to 50 percent of patients using chronic opioid therapy for non-cancer pain abuse or misuse" -- "misuse or abuse their medications." Do you see that?
A. Yes.
Q. And have you ever looked at, reviewed any literature relating to how many patients -- relating to how many patients first

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misuse or abuse their medications before -- misuse or abuse opioid medications before transitioning to heroin?
MS. SCOLNICK: Object as to form.
A. I have -- I've cited to two studies here. One of them looks at patients who are being treated for chronic pain, and the outcome that they reported is stated here, that approximately 50 percent of those patients were found to misuse or abuse those medications.
The second article that I cited here looked at patients who are entering treatment for heroin addiction, and those patients reported -- actually I think the number is 75 percent entering treatment for heroin addiction reported that their first opioid use was an opioid medication -- a prescription opioid medication.
I can't extrapolate the findings of those studies. Those are the findings that they reported.
Q. Got it. Okay.
I -- I was wondering if you had read anything different. Anything outside of those two studies that you're describing.

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A. I have looked at other articles, yes.
Q. That look at the link between abusing prescription opioids and transitioning to heroin?
A. Not that I recall.
Q. Okay. In your experience, do you have a sense of -- have you developed a sense of how likely it is a person will become addicted to a prescription opioid if they take it exactly as the doctor prescribes it for the duration of time in which it was prescribed?
MS. SCOLNICK: Object as to form.
A. I don't think that anybody has an answer to that. There are clear risk factors that place a person at higher risk that we've discussed previously, but there's -- there's no clear answer to which patients and exactly, precisely what that risk is. Nobody knows the answer to that.
Q. When you're treating someone in the emergency room for an overdose, do you ever determine whether that person was misusing prescription opioids leading up to the overdose?

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MS. SCOLNICK: Object as to form.
A. Yes. We've had patients report to us that they misused the medications.
Q. Other than self-reporting, is there any way you could determine whether someone was abusing prescription -- whether an overdose patient had been abusing prescription opioids?
A. We would take into consideration a number of factors: the route of administration; if -- if we obtained any lab testing, that may give us some additional information; review of the OARRS report may give us information about polypharmacy. We look at all of those factors.
But that only tells us what the patient is taking. It doesn't necessarily tell us what the patient knows or what their perceived risk was. Sometimes they just don't know that taking medications together can be dangerous.
Q. And when you say that, you're talking about prescription medications?
A. Well, not necessarily. Drinking alcohol, using sleeping pills, sedating psychiatric medications can all contribute to

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the CNS and respiratory depression when taken with an opioid, and sometimes the patients just don't know.
Q. Okay.
MS. McNAMARA: I don't know how long we've been going, but I'm about to switch to a new topic.
THE WITNESS: This would be a nice time for a break for me.
MS. McNAMARA: Okay. Perfect.
THE VIDEOGRAPHER: Off the record at 1:50 p.m.
(A recess was taken.)
THE VIDEOGRAPHER: Back on the record at 2:05 p.m.
BY MS. McNAMARA:
Q. Welcome back.
A. Thank you.
Q. Dr. Papp, are you aware that MetroHealth has a pharmacy?
A. Yes, I am.
Q. And is that a retail pharmacy?
A. We have both an inpatient and a retail pharmacy.
Q. And is the inpatient pharmacy only

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open to MetroHealth inpatients?
A. I believe that's how it operates.
Q. Do you know whether the retail pharmacy is open to the public?
A. Yes, it is.
Q. Do you know approximately what percentage of prescriptions at the retail pharmacy are filled by MetroHealth patients?
MS. SCOLNICK: I'm going to object to beyond the scope. She can answer it.
A. I don't know the answer to that question.
Q. Do you know or have a sense of what percentage of the prescriptions you write are filled at the MetroHealth pharmacy?
A. I do not know.
Q. Do you recall a -- strike that.
Have you ever written an opioid prescription that was filled at MetroHealth pharmacy?
A. Again, I don't have any information about where prescriptions are filled. But having worked there for almost 18 years, I assume that some of those prescriptions were filled at our retail pharmacy.

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Q. Has the MetroHealth pharmacy ever called you with questions about an opioid prescription you wrote?
A. I don't recall.
Q. Have you ever heard of MetroHealth pharmacy calling a colleague with questions about an opioid prescription?
A. We have received calls from the pharmacists in the past regarding prescriptions written in the emergency department.
Q. And are you aware of MetroHealth pharmacy ever refusing to fill an opioid prescription written by someone in the emergency department?
A. Not to my knowledge.
Q. Based on your experience, do you have any reason to believe that anyone working at the MetroHealth pharmacy was diverting controlled substances for uses other than filling prescriptions written by licensed prescribers?
MS. SCOLNICK: Objection based on scope.
A. And I don't have any direct knowledge of the staffing of the pharmacy.

Q. So before this morning when I introduced myself, have you ever heard of Cardinal Health?
A. Yes.
Q. In what context?
A. I believe they're one of the distributors for our hospital.
Q. They sell medications to MetroHealth pharmacy?
A. I'm not completely sure of the scope of the service that they provide to MetroHealth, but I know that we have a relationship with Cardinal Health.
Q. Have you personally in the course of your work ever had any with dealings with anybody from Cardinal Health?
A. Yes.
Q. Who was that?
A. I don't remember names, but I did receive a $35,000 education grant from Cardinal Health to educate providers on safer opioid prescribing in the emergency department.
Q. And when did you receive that grant?
A. 2017, I believe.

Q. Was that around the -- was that in connection with the launch of the office for opioid safety?
A. It was in that time frame, yes.
Q. So in the summer of 2017 time frame?
A. About that time. That sounds right.
Q. Any other interactions with Cardinal Health?
A. Not that I can recall.
Q. Have you ever heard of McKesson Corporation?
A. I've heard the name, yes.
Q. And in what context have you heard of McKesson?
A. I believe they're a manufacturer.
Q. Have you ever had any professional interactions with anybody from McKesson?
A. Not that I can recall.
Q. Have you ever heard of AmerisourceBergen Drug Corporation?
A. Yes.
Q. In what context?
A. I believe they're also a distributor that is affiliated with our hospital.
Q. And have -- have you personally had any dealings with anybody from AmerisourceBergen?
A. Not that I recall.
Q. Have you heard of H.D. Smith?
A. No.
Q. What about ANDA, A-N-D-A?
A. No.
Q. Miami-Luken?
A. No.
Q. Prescription Supply, Inc.?
A. No.
MS. McNAMARA: I think that's all I have. Thank you very much for your time. I appreciate it.
THE WITNESS: Thank you.
MR. DAVISON: Could we go off the record for a minute?
THE VIDEOGRAPHER: Off the record at 2:11 p.m.
(A recess was taken.)
THE VIDEOGRAPHER: Back on the record at 2:12 p.m.
EXAMINATION OF JOAN PAPP, M.D.

BY MR. DAVISON:
Q. Dr. Papp, thank you for your time so far today. We will try and keep this brief to get you out of here.
As I mentioned, my name is William Davison. I'm from the law firm of Ropes & Gray, and I represent Mallinckrodt Pharmaceuticals, which is one of the manufacturers that's a defendant in this litigation.
So we talked a lot earlier about prescription opioids, pretty much all day. You still prescribe prescription opioids to appropriate patients today; is that correct?
A. I prescribe opioids based on the risks and the benefits to patients, yes.
Q. Okay. And what are the benefits of prescription opiates?
A. Reduction in pain.
Q. And are there particular benefits to using an opioid versus, say, some other type of prescription pain medication?
A. It really is very patient and condition specific. Some patients have allergies to non-opioid medications. There are

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other specific conditions in which an opioid is a better choice than a non-opioid medication.
Q. And so for -- for each prescription that you may write of -- of an opioid, you would weigh the benefits you've discussed with the risks of that particular class of medications. Is that fair?
A. Yes.
MS. SCOLNICK: Object to the form.
A. Yes.
Q. Okay. So I want to discuss briefly the information you rely upon in weighing the risks and the benefits in making that determination.
Do you rely on the FDA-approved label in evaluating the risks of prescription opioids?
A. Yes, I do.
Q. Okay. Do you rely on your med school education in weighing the risks and the benefits of prescription opioids?
MS. SCOLNICK: Object to the form.
A. Yes. However, that education has evolved since medical school.
Q. Fair enough. Do you also rely on

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your experience over time in weighing the risks and benefits of opioid medications?
A. My continuing education, yes.
Q. Okay. Do you rely upon scientific literature in weighing the risks and benefits of opioid medications?
A. Yes.
Q. Do you rely upon government guidance?
A. Yes.
Q. Do you rely upon specific conversations with the patient in question relating to particular risk factors?
A. Yes.
Q. Do you rely upon looking at the OARRS database for additional information?
A. Yes.
Q. Are there any other information that you rely upon in determining and weighing the risks and benefits of prescribing prescription opioids?
A. There may be other factors. Occasionally, we get additional information from family members or other sources like EMS that brings a patient in. They may be able to

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provide us additional information. So I -- I would say that there may be, based on the individual patient.
Q. Can you think of any other information that you would rely upon that you would listen to instead of, say, the FDA warning label?
MS. SCOLNICK: Object to the -- to the form, and I didn't hear it.
MR. DAVISON: Oh, I apologize.
Q. Can you think of any other sources of information that you would rely on instead of the FDA warning label?
MS. SCOLNICK: Object as to form.
A. I think it's a synthesis of all of these sources together that help to make a -- to help us to weigh those benefits.
Q. Okay. And those were all of the sources we just discussed; is that correct?
A. Correct.
Q. And as of right now, you can't think --
A. And --
Q. -- of any -- I'm sorry.
A. And potentially some other

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sources --
Q. Okay.
A. -- that I can't re- - can't think of right now.
Q. Okay. Moving to a different area, are you familiar with the distinction between generic and branded prescription medication?
A. Yes.
Q. Okay. And do you write generic prescriptions?
A. Yes.
Q. And have you written branded prescriptions in the past?
A. Yes.
Q. Okay. And when you write a generic description [sic] is that for a particular manufacturer's product?
A. No.
Q. Going -- we talked earlier -- and I apologize for jumping around. I'm just trying to move quickly for you here.
We talked about the peer review board a little bit ago, and I just wanted to make clear, simply because a prescriber was evaluated by the peer review board, that does

not mean he had written a prescription that was not medically necessary. Is that fair?
A. That is correct.
Q. And even if it was suggested that that prescriber be retrained, that does not mean that he had written a prescription that was not medically necessary, correct?
MS. SCOLNICK: Object as to the form.
A. And I would restate that.
Q. Uh-huh.
A. State that we provide additional support and resources to those providers rather than stating that we re- -- we don't retrain --
Q. Fair enough.
A. -- providers.
Q. Let me -- let me restate it, then --
A. Okay.
Q. -- with that.
Simply because the peer review board provided additional support and resources to a provider does not mean that that provider had written a prescription that was not medically necessary, correct?

MS. SCOLNICK: Object as to form.
A. That does not mean that that prescription was not medically indicated.
Q. And are you personally aware of any opioid prescription written by a MetroHealth prescriber that was not medically necessary?
MS. SCOLNICK: Object as to form.
A. I -- I don't know that I can accurately answer that question. We evaluate the prescriptions that come to our attention based on evaluation of specific patients and review of their medical records, but I've not been aware of any prescriptions that are illegitimate or inappropriate.
Q. Okay.
MR. DAVISON: That's -- that's all I have. We can go off the record.
THE VIDEOGRAPHER: Off the record at 2:18 p.m.
(A recess was taken.)
THE VIDEOGRAPHER: Back on the record at 2:20 p.m.
EXAMINATION OF JOAN PAPP, M.D.
BY MR. HERMAN:
Q. Hi, Dr. Papp. I'm Steve Herman

from Zukerman Spaeder here on behalf of CVS Indiana, LLC, and CVS Rx Services, Incorporated. I introduced myself a while ago, but nice to meet you again. I just have a few questions for you.
You un- -- first off, you understand that the rules that Colleen gave you at the beginning of the deposition still apply now?
A. Yes.
Q. And that you're still under oath?
A. Yes.
Q. Okay. And if you don't understand a question that I ask, just let me know and I'll try to improve upon it.
A. Got it.
Q. Okay. Before I introduced myself today, were you aware that CVS Indiana, LLC, was a Defendant in this case?
A. No, I was not.
Q. Were you aware that CVS Rx Services, Incorporated, was a Defendant in this case?
A. No.
Q. Were you aware that Rite Aid of

Maryland is a Defendant in this case?
A. No.
Q. Were you aware that Walgreens is a Defendant in this case?
A. No.
Q. Were you aware that Walmart is a Defendant in this case?
A. No.
Q. Do you have any personal knowledge of why CVS Indiana, LLC, was named as a Defendant in this case?
A. I do not.
Q. Do you have any personal knowledge of why CVS Rx Services, Incorporated, was named as a Defendant in this case?
A. I do not.
Q. Do you have any personal knowledge of why Walmart was named as a Defendant in this case?
A. No.
Q. Do you have any personal knowledge of why Rite Aid was named as a Defendant in this case?
A. No.
Q. Do you have any personal knowledge

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of why Walgreens was named as a Defendant in this case?
A. No.
Q. Are you personally aware of any facts that would support any claims against CVS Indiana, LLC?
MS. SCOLNICK: Object as to form.
A. No.
Q. Are you personally aware of any facts that would support claims against CVS Rx Services, Incorporated?
MS. SCOLNICK: The same objection.
A. I have no knowledge to support or refute.
Q. Okay. Do you have any knowledge to support or refute any of the claims against Walmart?
A. No.
Q. Rite Aid of Maryland?
A. No.
Q. Walgreens?
A. No.
Q. Are you personally aware of any conduct by CVS, Rite Aid, Walgreens, Walmart, or Walgreens [sic] that caused harm to Cuyahoga

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County?
A. Not to my knowledge.
Q. Okay. Have you had any communications with CVS regarding prescription opioids?
A. It's likely. I can't remember any specific instances, though.
Q. Okay. And were those communications just about filling prescriptions?
A. Often we get calls from retail pharmacies regarding prescriptions.
Q. Okay. So --
A. And I'm -- I'm confident that at some point in my career I've received a call from CVS.
Q. But same question with regard to Wal- -- or Rite Aid?
A. I probably received calls from all local retail pharmacists --
Q. Okay.
A. -- at one point or another.
Q. Okay. But you don't recall any of those specific conversations?
A. Not any specific conversations.

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Q. Okay. And are you aware that CVS, Rite Aid, Walgreens, and Walmart are named in this litigation as distributors and not as retail pharmacies?
A. Only the information that you've provided to me here today.
Q. Okay. Dr. Papp, are you aware of how many opioid pills MetroHealth prescribed in 2018?
MS. SCOLNICK: Object as to scope.
A. I don't have those numbers in front of me.
Q. Are you aware that MetroHealth prescribed millions of pills -- MetroHealth provi- -- prescribers prescribed millions of opioid pills in 2018?
A. Again, I -- I know -- I can't give you a precise number, but I -- I am aware that millions of pills have been prescribed.
Q. And MetroHealth prescribers have pre- -- prescribed millions of pills each year from 2010 all the way through 2018?
A. Yes.
Q. Are you aware of that?
A. Yes.

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Q. Okay. And just by looking at those number of pills, you can't tell whether any of those prescriptions for prescription opioids were medically appropriate?
MS. SCOLNICK: Object as to form.
A. Not without a detailed review.
Q. That's right. You'd need to do a detailed review of each individual prescription?
A. We would be able to determine whether or not a prescription complied with CDC guidelines after we've performed a detailed review.
Q. Okay. But --
A. But --
Q. I'm sorry. Were you finished? I didn't mean to speak over you. Sorry.
A. I would add that in 2017 and early -- at the end of 2017, we began linking a diagnosis to each opioid prescription, so that would help us to determine if the prescription was linked to an active cancer or a palliative care --
Q. Okay.
A. -- opioid prescription. So that

would give us a little bit of additional information. But, again, that doesn't give us the full picture, necessarily, all the time.
Q. Yeah. I think my question wasn't a particularly good one, maybe. What I -- what I was trying to ask is, you couldn't tell anything about the medical appropriateness of MetroHealth prescribers' prescriptions just by looking at the absolute number of pills?
A. Not necessarily, no.
Q. You'd have to do the type of drilling down on individual cases that you began to discuss?
A. To evaluate a particular provider, yes.
Q. Okay. And you'd need to know about each individual patient?
A. We would need to have --
MS. SCOLNICK: Object as to form.
A. We would need to have additional information to determine appropriateness.
Q. Okay. And you might even -- you'd need to look at the diagnosis, correct?
A. And --
MS. SCOLNICK: Object as to form.

A. And other factors.
Q. Some of the factors you've discussed earlier, like the risk benefit calculation?
A. Right.
Q. And you might need to speak with the specific provider to get additional information?
A. Right. And a review of their pertinent past medical history and other medications that they're taking.
Q. Okay. And that's the kind of analysis that a provider should do each time that they write a prescription for a prescription opioid, correct?
A. Yes.
Q. Okay. And MetroHealth hasn't prohibited the -- its providers from prescribing prescription opioids, right?
MS. SCOLNICK: Object as to scope.
A. No.
Q. You could write a pres- -- you could write one of your patients a prescription for prescription opioids today, correct?
A. Yes.

Q. Why hasn't MetroHealth prohibited prescribers from writing prescriptions for prescription opioids?
MS. SCOLNICK: Object as to scope.
A. Because there are times when opioids are appropriate to treat pain.
MR. HERMAN: Okay. Thank you. I have no further questions.
MS. SCOLNICK: Any other questions?
(No response.)
MS. SCOLNICK: Okay. This deposition is completed.
THE VIDEOGRAPHER: Off the record at 2:27 p.m.
(Deposition concluded at 2:27 p.m.)
~ ~ ~ ~ ~

Whereupon, counsel was requested to give instructions regarding the witness's review of the transcript pursuant to the Civil Rules.

SIGNATURE:
Transcript review was requested pursuant to the applicable Rules of Civil Procedure.

TRANSCRIPT DELIVERY:
Counsel was requested to give instructions regarding delivery date of transcript.

REPORTER'S CERTIFICATE

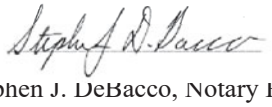
The State of Ohio,)
SS:
County of Cuyahoga.)

I, Stephen J. DeBacco, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, JOAN PAPP, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

I do further certify that I am not a relative, counsel or attorney for either party, or otherwise interested in the event of this action.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal of office at Cleveland, Ohio, on this 8th day of February, 2019.



Stephen J. DeBacco, Notary Public
within and for the State of Ohio

My commission expires September 30, 2022.

Veritext Legal Solutions
1100 Superior Ave
Suite 1820
Cleveland, Ohio 44114
Phone: 216-523-1313

February 8, 2019

To: Judith Scolnick

Case Name: In Re: National Prescription Opiate Litigation v.

Veritext Reference Number: 3216350

Witness: Joan Papp, M.D. Deposition Date: 2/5/2019

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the witness review the transcript and note any changes or corrections on the included errata sheet, indicating the page, line number, change, and the reason for the change. Have the witness' signature notarized and forward the completed page(s) back to us at the Production address shown above, or email to production-midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of this letter, the reading and signing will be deemed waived.

Sincerely,
Production Department

NO NOTARY REQUIRED IN CA

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3216350
CASE NAME: In Re: National Prescription Opiate Litigation v.
DATE OF DEPOSITION: 2/5/2019
WITNESS' NAME: Joan Papp, M.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

_____ _____
Date Joan Papp, M.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3216350
CASE NAME: In Re: National Prescription Opiate Litigation v.
DATE OF DEPOSITION: 2/5/2019
WITNESS' NAME: Joan Papp, M.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

_____ _____
Date Joan Papp, M.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;
They have listed all of their corrections in the appended Errata Sheet;
They signed the foregoing Sworn Statement; and
Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this _____ day of_____, 20____.

_____
Notary Public

_____
Commission Expiration Date

ERRATA SHEET
VERITEXT LEGAL SOLUTIONS MIDWEST
ASSIGNMENT NO: 2/5/2019

PAGE/LINE(S) / CHANGE /REASON

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Date Joan Papp, M.D.

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____
DAY OF _____, 20_____ .

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Notary Public

_____
Commission Expiration Date

z

Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

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Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

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